GUY'S
HOSPITAL
GAZETTE

NEW SERIES
VOL. 81

1967

Guy's Hospital Gazette.

Guy's Hospital Gazette.

THE WILLS LIBRARY
GUY'S HOSPITAL MEDICAL SCHOOL

THE WILLS LIBRARY,
GUY'S HOSPITAL,
LONDON, S.E.1.

GUY'S HOSPITAL GAZETTE

VOL. LXXXI

1967

INDEX

A

Aberdeen, E. Hearts in other places? (C), 14
Abortion, (Keith Simpson) (O), 498; (P) 24; (C) 67, 91, 115, 268, 424, 487, 498, 541
Accidents (P) 321
Adoptions, 157
Aldosteronism, primary (Anna Maria Tihanyi) (O), 502 (C), 543
Allen, T. S. College (C), 542
Ambulance education (C), 363
American elective (A. Calin) (O), 357, correction, 423
Amsden, A. L. Voluntary help at Guy's (O), 85
Ancillary/Auxiliary (C), 584
Anderson, J. A. D. Outside the ivory tower (O), 526
Andrews, J. E. Another side (C), 43
Apartheid in sport (C), 117, 177
Appleby, M. I. and others. Cricket Club (C), 337
Appointments :
  Beckenham Hospital, 454, 671
  Evelina Hospital, 292, 454
  Guy's Hospital :
    House officers, 292, 454, 670
    Registrars, 493
  Kent and Sussex Hospital, 671
  Lewisham Hospital, 293, 454, 671
  Miller Hospital, 293, 454, 671
  New Cross Hospital, 293, 454, 671
  Orpington Hospital, 293, 454, 671
  Pembury Hospital, 293, 454, 671
  St. John's Hospital, 293
  St. Nicholas Hospital, 293, 454, 671
  St. Olave's Hospital, 293, 454, 671
Appointments vacant :
  Beckenham Hospital, 398
  Buckland Hospital, 520
  Evelina Hospital, 99, 181
  Exchange registrar, 237
  Greenwich District Hospital, 646
  Guy's Hospital :
    Anaesthetics. Registrar, 370, 422, 568, 591
    Child Psychiatry. Registrar, 493
    Clinical Pathology. Registrar, 519
    S.H.O., 453
    Conservative Dental Surgery. Registrar, 620
    Dental H.S., 345, 398
    Dental Hygienists, 520
    Dental Officer, 99
    Dental Prosthetics. Registrar, 49
    Dental registrars, 181
    Dermatology. Registrars, 620
    Diagnostic Radiology. Registrar, 49, 181, 547
    Endocrinology & Isotopes. Registrar, 49
    E.N.T. Registrar, 22
    House appointments, 99, 568
    Junior Staff, 50, 212, 237
    Medical Registrar, 49, 370
    Obstetrics. Registrar, 591
    Ophthalmology. Registrar, 98, 345, 422, 620
    Orthopaedics. Registrar, 237
    Paediatrics. Registrar, 76, 181
    Psychological Medicine. Registrar, 49, 620
    Staff Dental Officer, 620
    Surgical Registrar, 345, 370
    Thoracic Surgery, Registrar, 345, 646
  Guy's Hospital Dental School :
    Children's Department. Lecturer, 237
    Conservative Dental Surgery. Demonstrator, 292
    Lecturer, 181, 453, 519
  Guy's Hospital Medical School :
    Bacteriology. Lecturer, 49 98
    Junior Staff, 238
    Paediatrics. Assistant Director, 547
    Pharmacology. Lecturers, 124
    Studentships, etc., 238
    Surgery. Lecturer, 345
  Guy's—Maudsley :
    House Officer, 670
    Registrar, 345
    S.H.O., 22, 345
  Guy's Hospital and S.E.M.R.H.B. :
    Anaesthetics. Registrar, 591
    Orthodontics. Registrar, 453
    Physical Medicine. Registrar, 345
    Psychiatry. Registrar, 49 98. 647
  Hither Green Hospital, 398
  Lewisham Hospital, 398
  Miller General Hospital, 237, 398
  New Cross Hospital, 100
  New Cross and St. Olave's.
    Pathology. S.H.O., 237
  Orpington Hospital, 298
  Pembury Hospital, 398
  St. Olave's Hospital, 493
Archaeological Society :
  evidence from Guy's, 304
  notice, 304
Association football : 121, 154, 546, 588, 643
  A.G.M., 289
  Blues, 644
  review, 46
  v. Chelsea, 669
  v. Icarus, 567
  v. K.C.H., 618, 669
  v. The London, 97, 210
  v. L.S.E., 618
  v. Manor Sports, 567
  v. Middlesex Hospital, 122
  v. Q.M.C., 669
  v. R.D.H., 645
  v. St. Bart's Hospital, 97
  v. St. Thomas's Hospital, 122, 646
  v. R.M.A. Sandhurst, 589
  v. Sir John Cass, 619
  v. Staff XI, 210
  v. Sussex University, 589
  v. University College, 645
  Students v. Staff, 589
Athletics, 342, 367, 368, 519, 666
  A.A.A. Championships, 396
  University of London Championships, 264
  United Hospital Championships, 342
  United Hospitals. Field Events, 318
  Sports Day, 288
  v. Goldsmiths & College of Estate Management, 291
  v. Imperial College, 318
  v. Middlesex v. London, 343
  v. St. Mary's Hospital, 291
Atkins, Professor Sir Hedley (P), 372
  New Year Honours, (P), 323

B

Baby, battered (K. Simpson) (O), 536, (C), 563
  play in relationship to the development of (D. F. Egan) (O), 299
Bailey, Joan Dental auxiliaries, 445
Baker, Mr. and Mrs. A. (P), 298
Baker, C. G. going, going (C), 252
  wedding, 3
Baker, Mrs. C. (P), 350 (C), 362
Baker, G. C. W. consultant appointment, 298
Baker, I. A. Efficiency (C), 70
Baker, Joan. Consultant appointment, 375
Barber, H. (P), 402
Barford, D. Sports section editorial (C), 117
Barkhan, P. Haematology at Guy's (O), 403
Batty Shaw, A. Browne, Osler and Guy's (C), 613
Baxter, E. W. Dr. Vertue (C), 42
Beaumont, G. F. *Pocket medicine* (R), 120
Beevers, R. Compassion (C), 662
Berry, H. :
  Andre Previn, 582
  Music, 638
  Well? (C), 286
Biochemistry. Hopkins prize, 13
Birds in poetry and prose, 204
Births, 22, 50, 76, 100, 125, 157, 181, 213, 238, 266, 294, 319, 345, 371, 399 ,423, 455, 520, 547, 568, 596, 621, 647, 673, 694
Blackburn, G. appointment (P), 79

Blaikley, J. B. :
externs' room, 480
New Year Honours (P), 323
Sir Herbert Eason (C), 615
Blood transfusion, history of (P), 624
Bloom, H. Evolution (C), 309
Blues Committee, 74, 518, 644
annual dinner, 184
Boat Club, 156, 367
A.G.M., 305, 367
blues, 644
Boston marathon, 567
Greenwich Regatta, 369
Hospital Boat race, 318
Kingston Head of the River, 211
Putney Town Regatta, 369
Reading Head of the River, 211
Richmond Regatta, 369
Thames Ditton Regatta, 318
Tideway Head of the River, 211
U.H. Bumping races, 318
University of London winter eights, 48
Boulton, D. Haunting casualties (C), 284
Boxing Club :
blues, 644
dinner, 81
history, 121 (C), 152
Matt Wells Trophy, 121
v. O.U.A.B.C., 21
Briggs D. S. and others. At what cost (C), 255
Bright, R. Picture (C), 335
Bristol dinner (C), 310
British Empire Cancer Campaign (2), 228
British Postgraduate Medical Federation, 41
Buchanan, T. M. Guy's through American eyes (O), 111 ; (C), 151
Broadbent, Pat. Simpson on sterilization (C), 615
Brock, Lord. Astley Cooper and Osler (C), 639
Browne, Sir Thomas (W. Hill) (O), 580, (C), 613
Budden, P. G. Old book—new books (C), 613
Building programme for G.P.s (C), 89
Burfoot, A. H. Great Maze Pond closes (C), 307
Tower block development (C), 88
War Memorial arch (C), 42
Burnford, D. Light on the externs' room (C), 614
Burns, T. H. S. Potty (C), 447
Proverbs (C), 44
Burry, H. C. Consultant appointment, 571
Burton, John (Dr. Slop), (W. Hill) (O), 509
Butcher, A. S. F. Abortion (C), 68

C

Calin, A. American elective (O), 357. correction, 423
Hodgkin's disease (O), 651
Cambridge University : pass lists :
M.Chir, 212
M.B., 76, 620
Cameron, J. S. Consultant post, 427
Words (O), 129
Camm, A. J. Effects of smoking (O), 185
Campion, P. C. S. First dental students (C), 584
Cann, R. J. retirement (P), 53
Cardiology quizette, 339
Carrick, D. My views on medical education (C), 310
Carton-Kelly, P. S. News of Old Guy's Men (C), 71
Cash, J. E. *Textbook of medical conditions for physiotherapists*. (R), 394
Physiotherapy in some surgical conditions. (R), 418
Changes of address, 22, 50, 76, 100, 125, 157, 213, 238, 266, 294, 319, 345, 370, 399, 423, 455, 495, 520, 547, 568, 596, 621, 647, 673, 694
Chartered Society of Physiotherapists : pass lists, 124, 319 422, 672, 694
Chemical warfare, (C. R. B. Joyce) (O), 217 : (P), 215
Chest clinic (P), 52
Chichester, Sir Francis (P), 296
Chickenpox and herpes zoster (C), 444, 487
Chinomania (C), 286
Chiswell, P. Superwhite coats (C), 392
Chittock, Mabel (C), 336
Chrimes, Sister D., retirement (C), 41, 177
Christ and life, 563
Christian Union, carol service, 41
Christmas, 1966 (P),, 2
Christmas, 1967, (P), 675
Christmas concert, 638
events, 677
number, 674
services in Chapel, 650
sisters' dinner, 45
staff-nurses' dinner, 73
Clarkson, Elizabeth, British Empire Cancer Campaign (C), 228
Clarkson, P. Guy's Royal Ascot Lunch Club (C), 363
Clifton-Crick, Rosemary. epitaph, 476
Clocks, (C), 72
Clubs Union, Rose Ball, 676
Cobell, D. Lust safe at last (C), 257
men as nurses (O), 436
Cohen, N. M. Ending the week-end (C), 17
College : and T.B. 583, 562, 614, 641
demolition of (C), 252 (P), 268
epitaph, 476
externs' room, 480
farewell to (P. M. F. Bishop), 460, (P), 456 (C), 511, 542
food in, 466 (C), 511
living in, 477
paintings, 599
College of Pathologists, pass lists, 76, 345
Collins, J. Mrs. Baker (C), 362
Commensals or parasites, 481
Common market, (P), 269
Communication, 109
Compassion, 612, 639, 662
Conjoint Board. Pass lists :
D.A., 76, 547, 672
D.C.H., 266
D.I.H., 455, 266
D.M.R.D., 76
D.P.M., 76
L.R.C.P., M.R.C.S., 100, 212, 266, 370, 455
Conn's syndrome (Anna-Maria Tihanyi) (O), 502 (C), 542
Conybeare, Sir John : (P), 23
Obituary, 27
(C), 30, 68, 114, 150
Cooper, Sir Astley, Osler and (C), 639
Cope, Sir Zachary. *Almroth Wright* (R), 205
Corby, Pat and Service, Pam. Coherent concern (C), 286
Correspondence, 14, 41, 67, 88, 114, 150, 176, 206, 225, 251, 281, 307, 334, 362, 392, 415, 444, 487, 511, 541, 562, 583, 613, 639, 662
Cosgrove, F. What is absolute (C), 283
Coulter, B. Old question—new answer, (C), 392
Cowan, R. E. Abortion (C), 115
Crafts, D. Cricket club (C)), 337
Cremin, B. J. consultant appointment, 242
Cricket Club : 235, 264, 289, 317, 342, 367, 396, 450 (C), 286, 337
averages, 492
Blues, 518
resume, 419
tour, 490
v. Beckenham, 265
v. Bognor, 490
v. Chichester Priory, 491
v. Crofton Park, 319
v. Cuckfield, 491
v. Dover, 343
v. Ferring, 491
v. Hampstead, 344
v. Hayling Island, 490
v. Honor Oak, 290
v. Horsham, 265
v. Lloyd's Bank, 452
v. London New Zealand, 452
v. Mayfair, 397
v. Met. Police, 420
v. the Mote, 397
v. Nomads, 420

v. Queen's Belfast, 368
v. Reigate Pilgrims, 319
v. St. Laurence, 343
v. St. Mary's (Cup), 397
v. St. Thomas's (Cup), 318
v. Streatham, 420
v. Teddington, 343
v. U.C.S. O.B., 420
v. Wallington, 398
v. the Wanderers, 290
v. Westminster (Cup), 290
Past v. Present, 305, 368
single wicket, 419
Criticism :
Man for all seasons, 38 (C), 71
Music Club concert, 174
Recruiting Officer, 414
Residents' Play, 134
Ten little niggers, 132
Curry, N. In the swim (C), 255
Cutler, R. Dr. Conybeare (C), 114

D

Davies, D. A. Legend of woe (C), 151
Davies, G. L. College and T.B. (C), 562
Medicine at the cross roads (C), 281
Musical bloomer (C), 338
Musical notes (O), 222
Still in the valleys (C), 16
Davies, P. M. *Medical terminology for radiographers* (R), 356
Day, M.A. Retirement of Sister Chrimes (C), 41
Death (P), 521
moment of, 601
Deaths, 22, 50, 125, 181, 213, 238, 266, 345, 371, 391, 423, 495, 547, 568, 596, 673
Dejours, P. Respiration (R), 66
Dental auxiliaries, school for at New Cross Hospital (P. W. F. Lambden) (O), 383 (C), 17, 42, 415, 444, 512, 544, 585, 644
Dental Ball, 540, 564
Dental mechanics, (C), 544
Dental School :
Annual clinical meeting, 40, 79, 103, 173
course in conservative dentistry, 152, 441
mobile unit, 485
Dental Society, annual dinner, 40
A.G.M., 338
Dental students ;
first (C), 584
welcome to, 561
Dermatology ; international meeting, 438
quizette, 311
Disabled (P), 426
Dispensary (C), 448, 514
Dogs, Mr. Wheeler's (P), 550
Dominick, J. C. And so to bed (C), 258
college and T.B. (C), 614
stargazing (C), 310
Doubleday, Edith, 417
Doubleday, F. N., W. M. Mollison (C), 90
Doubleday, H. Dr. Vertue (C), 42
Douglas, J. G. Still changing (C), 17
Drink and driving (O), 550
Driving, drink (or drugs) and, (O), 550
Drug addiction, (P), 401 (C), 446, 487 (O), 626
Drugs, conference, 153
and driving (O), 550
D'Souza, M. F. "hang it all" (C), 335
Dunn, K. N. D., death of (P), 242

E

Eason, Sir Herbert (C), 615
Eckhoff, Nils : appreciation, 428
retirement (P), 425
What is plastic surgery (O), 430
Egan, Dorothy F. Play in relation to the development of babies and young children (O), 299
Elderly in hospital beds (P), 320 (O), 324 (A. J. Rosin)
Ellis, F. G. consultant appointment, 458
Ellis, J. D. Chinomania (C), 286
Elsdon-Dew, R. Sports section editorial, (C), 117
Endocrinology quizette, 507, 543
Engagements, 157, 238, 345
Evans, P. R. : in Vietnam (C), 16, 176
Evans, S. Who seeks him where (C), 253
Evolution, (P), 78, 321
Examinations, (P), 522
Externs' room, 480, (C), 614

F

Fairley, A. consultant post, 158
Farrell, R. H. obituary, 6
Fencing Club, 519
59 club, (C), 44
Fizzio Ball, 489
Fleming and Paterson, *Mental disorder and the law* (R), 66
Flint, F. J. (C), 615
Fluorine, medical importance of (R. H. Savage) (O), 159
Food and the college (C), 466, 511
Forman, L. retirement of (P), 458
Forrest, J. O. Non-surgical treatment of periodontal disease (O, 104
Frances, H. W. S. G P building programme (C), 89
Freeman and Bracegirdle *Atlas of histology* (R), 176
Fullerton, Jane M. Morbid anatomy in old age (O), 405 (C), 446

G

Gaches, C. G. C. Hallet prize (C), 177
Gain, M. Problems uncommon and common (C), 177
Garland, G. W. death of, 25
Garrett, Christine. Palm and finger prints (C), 16
Gaunt, W. A. and others. *Advances in dental histology* (R), 393
General Nursing Council. Pass lists, 178, 213, 449, 672
General practice, student view of (G. A. Machin) (O), 57
thoughts and facts on (D. W. Mayman) (O), 609
General practitioners and residents (P), 267
building programme for (A. Lester) (O), 34
Geriatric medicine quizette, 442
Gibberd, G. F. : appreciation, 342
retirement of (P), 184
Gilbert and Sullivan, 356
Giles, S. F. Failing and shifting (C), 92
Glynn, J. E. *Hand surgery* (R), 120
Going down dinner, 184
Golf Club : 617
annual dinner, 184
Blues, 644
Dental staff v. students, 317
Hospital cup, 21, 619
London University championships, 289
review of 1966, 21
v. President's team, 291
v. St. Thomas's 344
Gordon, Alexander, and puerperal fever, (W. Hill) (O), 556
Graham, J. M. Cannabis (C), 488
Grants, (C), 206
Gregson, J. S. Another guise (C), 285
Ambulance education (C), 363
Griffiith, M. S. : College and T.B. (C), 583, 641
Failing and shifting (C), 115
Grimble, A. S. Special answer (C), 282
Grove, S. S. Medicine in S. W. Africa, 7
Guild of Ex-Patients, 244
Guy's Alumni luncheon, 288
Guy's Bristol dinner, 415
Guy's diary, 1 16, 53, 79, 103, 128, 158, 184, 216, 242, 271, 298, 323, 349, 375, 402, 427, 458, 497, 523, 550, 571, 599, 625, 650, 676

Guy's Men, news of (P), 52, (C), 71
Guy's Royal Ascot Lunch Club, (C), 363
Guy's Hospital : anaesthetics at (A. M. Hutton), 376
seen through American eyes (T. M. Buchanan) (O), 111 (C), 151
Guy's Hospital Gazette : awards, 3
committee, 53
editorial changes, 3, 53, 650
1877 and 1917, 241, 260, 278, 306, 361, 417, 449, 538
sixty years ago, 538
Guy's Hospital Medical School prizes, 157
Guy's Hospital Society :
Bournemouth and Wessex, 579
E. Anglian dinner, 288
S. Wales and Monmouthshire, 81
Guy's Hospital Reports, issues for students (P), 51

H

Haematology at Guy's (P. Barkhan) (O), 403
Hallet Prize (C), 177
Haslewood, G. A. D. Hopkins Prize for Biochemistry, 13
Hayes G. obituary, 271 (C), 334
Hayton-Williams, D. S. Food and the college (C), 512
Heart as a musical box (D. N. Ross) (O), 272
Heart disease (C), 14
Helliwell, P. J. appointment as Superintendent (P), 53
Herbert, W. E. appreciation, 525
Emeritus professorship, 458
retirement of, (C), 562
Herpes zoster and chickenpox (C), 444, 487
Hickson, P. and others. Guy's Bristol dinner 415
Hill, W. Missing books (C), 640
Wills Library antiquities, 381, 410, 434, 484, 509, 539, 556, 580, 607, (C), 613, 636, 657
Hillier, M. J. H. Last word (C), 364
Love is more than . . . (C), 227
Hippies and weeds, 611
Hockey Club : 154, 179, 588, 667
A.G.M. 289
Blues, 644
dinner, 221
extra pitch, 450
Festival, 210
Ladies, 114, 211, 668
Paignton Festival, 236
review, 46
University of London Cup, 645
v. Bexley Heath, 21
v. Gore Court, 123
v. Gravesend, 668
v. Imperial College, 645
v. Nuneaton, 619
v. Romford, 47
v. St. Barts, 47
v. Sevenoaks, 123
v. Surbiton, 668
v. S. Saxons, 590
v. Tulse Hill, 75
v. Walton, 97
v. Wimbledon, 668
past v. present, 67
Spirochaetes v. Freshers, 590
Hodgkin, Thomas, grave of, 656
Hodgkin's disease (A. Calin) (O), 651
Homosexuality (P), 323
Honor Oak Park, changes 450, 513 (C), 583, 616
Honours List, 25
Hooper, K. it's improper (C), 284
Hopkins Prize for Biochemistry, 13
Hospital finance (P), 23, (C), 70, 151
Hospital information, 22, 49, 76, 98, 124, 157, 181, 212, 237, 266, 292, 319, 345, 370, 398, 422, 453, 493, 519, 547, 568, 591, 620, 646, 670, 694
Hospital medicine (P), 1
Hostels, (C), 255
Hunt, P. R. Midsummer ball (C), 336
Hunt. R. 128
Hunter, D. Need for a social work service in hospital to-day (O), 82
Hunter-Craig, C. Sports section (C), 91
Hutton, A. M. Anaesthetics at Guy's (O), 376

I

Illingworth, R. S. *Common symptoms of disease in children* (R), 515
Industrial medicine (Wills Library Antiquities), 410
Infectious disease quizette, 388
Inflams, 41
Innominate club, 184
International Biological Programme (P), 157
Ive, I. Disproportionate players, (C), 640

J

Jack, T. M. Obeying is not a duty (C), 309
Jeffss, J. V. consultant post, (Pe.), 25
John, W. R. B. and others. At what cost (C), 255
Johnson, Anne M. Uniform changes (C), 663
Jones, Roddy, 546
Joseph, J. No tariffs (C), 307
Joyce, C. R. B. How to win wars without actually killing—or how to kill people without actually trying (O), 217
Judo, 643
Junior Hospital Doctors Association (P), 648

K

Keable-Elliott, R. A. No deafened ear (C), 91
Kelsey Fry ; consultant appointment, 102
Keen, H. 158
Kieran, E. Pharmacy (C), 448, 514
Kind of living, 477
King-Turner, Elizabeth A. Any figures (C), 258
Knight, R. appointment (P), 79
Knowles, J. H. *Teaching hopital—evolution and contemporary issues* (R), 314
Knox, R. : Microbiology at Guy's (O), 621
Missing books (C), 640
Krupp, M. A. *Physician's handbook* (R), 149

L

Ladies' Association, 664
bazaar, 563
Lambden, P. W. F. The school for dental auxiliaries, New Cross Hospital (O), 383, (C), 444, 512, 544
Lane, R. H. S. Students' Club, 93
Lanyon, S. Questionable administration (C), 584
Latham, B. A. consultant post, 550
Laurence, K. M. Plastic coil for silver spoon (C), 256
Lawn Tennis, 421, 518
Lessof, M. consultant appointment (P), 53
Lester, A. Building programme for GPs (O), 34, (C), 89
Levy, Dr. (P), 296
Lewis, T. L. T. Abortion or abort (C), 67, 541
Lockhart, R. D. and others. *Anatomy of the human body* (R), 65
Lonbay, E. L. Matter of Life and Death (C), 392
London Medical Group, 579
London University : Pass Lists :
B.D.S., 76, 494, 520
D.P.H., 422
D.Sc., 345
M.B., B.S., 76, 266, 422, 454, 672
M.D., 76, 422
M.Phil., 520
M.S., 494
M.Sc., 620
Ph.D., 76, 345, 422, 520, 620
Recognition of teachers, 458

Lost friend, 576
Loomes, E. How's that (C), 286
Lowe, Peter, (W. Hill) (O), 434
Lux, L. B. Dental auxiliaries (C), 17, 512, 585
  Home guard (C), 150
  students' grants (C), 225, 365

M

McColl, I. Moynihan fellowship, 102
  Readership, 402
MacDonald, I. appointment of Professor, 350
McGill, I. G. Herpes and chickenpox (C), 487
MacKeith, R. C. Miss G. Saint (C), 15
McKeown, T. and Lowe, C. R. *Introduction to social medicine* (R), 233
MacManus, Emily : 41
  Miss Sidney, 614
  of course discipline is a dirty word (C), 308
Maberley, M. Moor from Mona Heights (C), 116
Machin G. A. Student view of general practice (O), 57
Man (P), 157
Marten, Benjamin and Tuberculosis (W. Hill) (O), 607
Marriages, 22, 157, 181, 213, 238, 371, 433, 495, 596 673, 694
Matron's Ball, 416
Mayman, D. W. Thoughts and facts on general practice (O), 609
Maynard, J. Consultant appointment, 242
Maze Pond, 322
Meacock, S. P. Food and the College (C), 511
  J. D. S. Thomas, (C), 513
Mechanisms of tooth support; a symposium (R), 315
Medical education :
  outside the ivory tower (J. A. D. Anderson) (O), 526
  prize essay (C), 310
  teaching period (P), 347
  T.V. (C), 562
Medical News prize essay (C), 310
Medical responsibility at law (K. Simpson) (O), 577 (C), 615
Medicine at the cross roads (C), 281
Medico-legal series (P), 496
  1. Abortion, 498
  2. Battered baby, 535
  3. Drink (or drugs) and driving, 551
  4. Medical responsibility at law, 572
  5. Moment of death, 601
  6. Dependence on drugs, 626
Merrill, Prof. I., 562 (C)
Merivale, W. H. H. Hallet prize (C), 177
Microbiology at Guy's (R. Knox) (O), 621
Midsummer ball, (C), 336
Miles, J. R. Blatantly beautifully blunt (C), 92
Milk (C), 392
Mollison, W. M. obituary, 54
  (C), 115, 90
Moore, J. The waiting game (C), 448
More, Sir Thomas (C), 71
Morris, E. D. Consultant appointment (P), 184
Morris, I. M. H.O.P. (C), 513
Mozart, W. A., 638
Munro, T. A. obituary, 5
Murphy, R. Potty (C), 447
Music, 362, 486, 505, 582, 638 (C), 286
  (G. L. Davies) (C), 338
Music Circle, 338, 391
Music Club, concert, 152, 174, (C), 176
Musical notes (G. L. Davies) (O), 222

N

National Health Service (P), 496, 623
  expenditure (C), 251
Neil, M. W. *Vertebrate biochemistry* (R), 149
Neild, N. Ban broken (C), 615
Neill, D. J. Readership, 427
Neurology quizette, 355
New Cross Hospital, school for dental auxiliaries (P. W. F. Lambden) (O), 383 (C), 444, 512, 544
Niggers, the (P), 1
Notley, R. G. 59 club (C), 44
Notices, 14, 40, 67, 81, 103, 152, 184, 221, 242, 288, 305, 338, 356, 441, 540, 563, 579, 611, 641
Names, (P), 156 (C), 544
Nurses, men as (D. Cobell) (O), 436
Nurses' Home, alterations to, 94
Nurses' League, 67, 103, 261, 489, 611, 641
  annual meeting, 184, 287
  journal, 242
Nurses' prize giving, 586
Nursing :
  administration quizette, 545, (C), 564, 584
  badges, 118
  borrowing, 262
  care of elderly, 366
  clubs, 341
  comfort, 207 (C), 286
  compassion, 612, (C), 639, 662
  conference on drugs, 153
  domestic duties, 316
  exam failures, 18, (C), 92, 115
  exchange visitors programme, 516
  gently does it (Joan Sawyer), (O), 229
  mechanical aids, 661
  P.T.S., (C), 43
  profession of service, 395
  St. Olave's prize giving, 232
  Sans everything, 416
  Sir Ivor Julian award, 517
  social events, 221
  staff changes, 18, 45, 73, 94, 119, 153, 178, 208, 232, 263, 288, 316, 341, 366, 395, 449, 482, 564, 642, 661
  staff nurses' study week, 73
  State Final pass lists, 178, 213, 449, 672
  teaching (C), 70, 91
  time off (P), 239
  uniform changes, 642, 663

O

Obesity, (P), 77
Obiter dicta, 131, 172, 259, 278, 310, 332, 341, 380, 514, 587
Obiter scriptum, 258
Obituary :
  Sir John Conybeare, 27
  R. H. Farrell, 6
  G. Hayes, 271
  W. M. Mollison, 54
  T. A. Munro, 5
  G. S. Rawson, 80
  Kathleen A. Shackle, 600
  G. Sperryn-Jones, 660
  H. N. St. John, 6
  J. D. S. Thomas, 441 (C), 513
  F. Tomlyn, 600
  H. St. H. Vertue, 4, 26
O'Brien, M.D. Bring and buy sale (C), 514
Ogg, C. Conn's syndrome (C), 543
O'Meara, P. Cony (C), 150
Orlans, S. Ah. (C), 255
Osler, William, Astley Cooper and (C), 639
  Sir Thomas Browne and (W. Hill) (O), 580 (C), 613
Orthopaedics, art of (T. T. Stamm) (O), 245
  quizette, 412
Outlook, (C), 584
Outpatients (P), 297
Oxford University Pass lists :
  B.M., 76, 266, 293, 422, 620

P

Paediatric department, sale, (C), 514
Palm prints, (C), 16
Papers by Guy's Men, 124, 294, 495, 595, 621
Park, alterations to, 214 (C), 42, 88, 307 (P), 349, 374
Parkinson, James (W. Hill) (O), 636

Pass lists :
Cambridge University,
M.B., 76, 620
M.Chir., 212
Chartered Society of Physiotherapists, 124, 319, 442, 672, 694
College of Pathologists, 76, 345
Conjoint Board,
D.A., 76, 547, 672
D.C.H., 266
D.I.H., 266, 455
D.M.R.D., 76
D.P.M., 76
L.R.C.P., M.R.C.S., 100, 212, 266, 370, 455
London University,
B.D.S., 76, 494, 520
D.P.H., 422
D.Sc., 345
M.B., 76, 266, 422, 454, 672
M.D., 76, 422
M.Phil., 520
M.S., 494
M.Sc., 620
Ph.D., 76, 422, 520, 620
Oxford University,
B.M., 76, 266, 293, 422, 620
Royal College of Obstetricians and Gynaecologists, 76, 212, 370, 494
Royal College of Physicians of Edinburgh, 212, 672
Royal College of Physicians of London,
Membership, 455
Fellowship, 293
Royal College of Physicians and Surgeons of Glasgow, 672
Royal College of Surgeons of Edinburgh, 345, 547
Royal College of Surgeons of England,
F.D.S., 76, 212, 454
F.F.A., 212, 620, 672
F.R.C.S., 76, 212, 547
L.D.S., 520
Royal College of Surgeons of Ireland, 345
Society of Apothecaries, D.I.H., 520
State Final, 178, 213, 449, 672
Passim, 1, 23, 51, 77, 101, 126, 156, 182, 214, 239, 267, 295, 320, 347, 372, 400, 424, 456, 496, 521, 549, 569, 597, 623, 648, 675
Paterson, R. C. Dental auxiliaries (C), 415, 664
Peacock, J. N. Dental auxiliaries (C), 42
Periodontal disease, non-surgical treatment (O), 104
Personal, 22, 76, 100, 125, 157, 181, 213, 238, 266, 294, 319, 345, 370, 399, 423, 455, 495, 520, 547, 568, 596, 621, 647, 672, 694
Photographic Society ; exhibition, 288
Physical medicine quizette, 279
Physiology theatre, (C), 91
Psychological Society, 611
Pitts, F. J. Compassion (C), 662
Sister Chittock, M.M. (C), 336
Pinker, G. D. and Roberts, D. W. T. *Short textbook of gynaecology and obstetrics* (R), 515
Plastic surgery (N. Eckhoff) (O), 430
Play in relation to the development of babies and young children. (D. F. Egan) (O), 299
Political geriatrics (P), 373
Politics (P), 424 (C), 487
Postgraduate meetings (P), 400
Pot (P), 401 (C), 446, 487
Previn, Andre, 582
Prize, 157, 212, 319, 595
Prize examinations (P), 295
Proceedings of a symposium on spina bifida (R), 315
Procter, E. Thoracic surgical Research Unit (1962-67) (O), 558
Proverbs, (C), 44
Pugh, D. R. Cony (C), 68
Pulse, 152
Pulvertaft, R. G. *Clinical surgery; the hand* (R), 65

Q

Quetta hospital (B. Harrison) (O), 331
Quick, C. White coats for lesser mortals (C), 310
Quizettes (P), 270
cardiology, 339
dermatology, 311
endocrinology, 507, 543
geriatric medicine, 442
infectious diseases, 388
neurology, 355
orthopaedics, 412
physical medicine, 279
radiology, 659

R

Radiology quizette, 659
Ramsay, A. M. and Edmund, R.T.D. *Infectious diseases* (R), 665
Rawson, G. death of, 53
obituary, 80
Reading, P. *Common diseases of the ear, nose and throat* (R), 120
Rebuilding (P), 597
Recknell, J. Cony (C), 114
Renal dialysis (P), 348 (C), 392
Residents' Ball, 221
Residents' Play (C), 42, 91
criticism, 134
history (P), 158
records, 216, 221
Resuscitation (P), 521
Reviews :
Beaumont, G. F. *Pocket medicine*, 120
Cash, J. E. *Physiotherapy in some surgical conditions*, 418
Cash, J. E. *Textbook of medical conditions for physiotherapists*, 394
Cope, Sir Zachary. *Almroth Wright*, 205
Davies, P. M. *Medical terminology for radiographers*, 356
Dejours, P. *Respiration*, 66
Fleming and Paterson, *Mental disorder and the law*, 66
Freeman and Bracegirdle, *Atlas of histology*, 176
Gaunt, W. A. and others. *Advances in dental histology*, 393
Glynn, J. E. *Hand surgery*, 120
Illingworth, R. S. *Common symptoms of disease in children*, 515
Knowles, J. H. *The teaching hospital—evolution and contemporary issues*, 314
Krupp, M. A. *Physician's handbook* 14th edn., 149
Lockhart, R. D. and others. *Anatomy of the human body*, 65
McKeown, T. and Lowe, C. R. *Introduction to social medicine*, 233
Mechanisms of tooth support; a symposium, 315
Neil, M. W. *Vertebrate biochemistry*, 149
Pinker, G. D. and Roberts, D. W. *Short textbook of gynaecology and obstetrics*, 515
Proceedings of a symposium on spina bifida, 315
Pulvertaft, R. G. *Clinical surgery; the hand*, 65
Ramsay, A. M. and Edmund, R. T. *Infectious diseases*, 665
Reading, P. *Common diseases of ear, nose and throat*, 120
Rudd, T. N. *Human relationships in old age*, 260
Schire, V. *Clinical cardiology*, 233
Schroff, F. R. *Basic dental anatomy and histology*, 314
Sutton, P. M. *Nature of cancer*, 66
Taylor, S, and others. *Short textbook of surgery*, 418
West, N. C. *Handbook for nurses*, 665
Whetnall, E. and Fry, D. B. *Deaf child*, 175
Winner, H. I. and Hurley, R. *Symposium on candida infections*, 233

Yeager, M. E. *Review of operating room manual* 175
Revolution (P), 240
Richards, L. G. Five less . . . oh no, 258
Rifle Club, 518
Robinson, E. Vive la difference (C), 286
Robinson, R. consultant appointment, 458
Romans were here (Angela Taylor) (O), 301
Roots, O. J. By the roots (C), 446
Rose Ball, 676
Rosin, A. J. Old folks in hospital beds (O), 324
Ross, B. A. H.O.P. (C), 583
Ross D. N. Heart as a musical box (O), 272
Rowe, A. H. R. Any old teeth (C), 512
readership, 427
Royal College of General Practitioners (P), 649
Royal College of Obstetricians :
M.R.C.O.G., 76, 212, 370, 494
Royal College of Physicians of Edinburgh, M.R.C.P., 212, 672
Royal College of Physicians of London,
Fellowship, 293
Membership, 455
Royal College of Physicians and Surgeons of Glasgow,
Fellowship, 672
Royal College of Surgeons of Edinburgh, Fellowship, 345, 547
Royal College of Surgeons of England :
F.D.S., 76, 212, 454
F.F.A., 212, 620, 672
F.R.C.S., 76, 212, 547
L.D.S., 520
Royal College of Surgeons of Ireland, 345
Rudd, T. N. *Human relationships in old age*, (R), 260
Rugby Club : 121, 154, 179, 546, 566, 588, 617, 666
A.G.M. 264
Ball, 14
Blues, 644
fixtures, 518
reports (C), 640
reviews, 19, 46
seven-a-sides, 235
tour 1967, 234
U.H.A.G.M., 396
U.H Centenary, 617, 643
v. Bedford, 644
v. Blackheath, 566
v. Bromley, 519
v. Cambridge University, 618
v. Coventry, 396
v. Devonport services, 180
v. Esher, 20
v. Exeter, 122
v. Fylde, 234
v. The London (A. final), 209
v. Nuneaton, 155
v. O. Alleynians, 155
v. O. Cranleighans, 20
v. Plymouth Albion, 47
v. St. Andrews University, 180
v. St. Marys' (A), 96
v. Sidcup, 588
v. Tredegar, 236
v. Vale of Lune, 234
v. Waterloo, 234
Rumsey, H. St. J. Star gazing (C), 334
Rushton, M. A. honours, 427

S

Sailing Club :
Brent regatta, 344
Chiswick regatta, 344
Horseferry regatta, 344
Saint, A. J. M. Cony (C), 69
Saint, Miss G. (C), 15, 72
True liaison (C), 72
St. John, H. N. Obituary, 6
Sans everything, 416
Sarah Swift House (P), 323, 338
Sargent, Sir Malcolm, 565
Savage, R. H. Medical importance of fluorine (O), 159
Sawyer, Joan Gently does it (O), 229
Scholefield, R. D. and others. At what cost? (C), 255
Schrire, V. *Clinical cardiology* (R), 233
Scientology (P), 126
Scotoma, 259
Scott, I. Old tavern clock (C), 72
Scott, S.C.C. Bristol dinner (C), 310
Security, (C), 253, (P), 230
Sembal Trust (C), 117
Service, Pam and Corby, Pat. Coherent concern (C), 286
Sex, (P), 183 (C), 226, 227, 256, 257, 258, 282, 284, 285, 308, 335, 364,
Shackle, J. W. College (C), 542
Shackle, Kathleen A. obituary, 600
Sharp, C. L. E. H. death of, 216
Sharp, H. C. H.O.P. (C), 616
Shock, bacteraemic (K. Stewart) (O), 351
Shroff, F. R. *Basic dental anatomy and physiology* (R), 314
Sidney, Miss T. 571 (C), 614
Silk, D. B. A. Cricket Club (C), 337
sports section editorial (C), 117
Simpson, K. :
abortion (O), 498
battered baby (C), 536, 563
dependence on drugs (O), 626
drink (or drugs) and driving (O), 551
medical responsibility at law (O), 577 (C), 615
moment of death (O), 601
Simpson, M. A. Ban on women (O), 577 (C), 615
Intellectual apartheid (C), 206
Student grants (C), 254
Sisters' Christmas dinner, 45
Smith, C. Dr. Evans in Vietnam (C), 16
Smith, Sir J. E. 657
Smith, R. C. Herpes zoster and chicken pox (C), 444
Smith, R. E. W. M. Mollison (C), 115
Smoking, effects of (A. J. Camm) (O), 185
Social responsibility (P), 51
Social work service in hospital (Diana Hunter) (O), 82
Society of Apothecaries, D.I.H., 520
Sociology Society (C), 584
South West Africa, medicine in (S. S. Grove) 7
Sperryn-Jones, G. obituary, 660
Sport, 19, 45, 74, 95, 121, 154, 179, 209, 234, 264, 289, 317, 342, 367, 396, 419, 450, 490, 518, 546, 566, 588, 617, 643, 666
editorial (C), 17, 91
Spring holidays (P), 182
Squash Club : 209
Blues, 644
hospitals cup, 211
results, 49, 123
Squash Club (Ladies), 155, 264
Staff Nurses' Christmas dinner, 73
Stafford Clark, D. Cannabis (C), 488
Stamm, T. T. Art of orthopaedics (O), 245
Stargazing (C), 310, 333
Sterilization (C), 615
Stewart, I. McD., G. More words (C), 228
Stewart, K. Bacteraemic shock (O), 351
Stiles, P. J. consultant appointment, 458
Stocker, A. H. More on more (C), 71
Stoker, D. J. Potty, 446
Stubbings, C. A. M. Theft in the Wills Library (C), 489
Student Education Committee, 242
Students : behaviour (P), 624
grants (P), 101, (C), 150, 225, 253, 307, 365
new entry (P), 549, 591
Students' Club : 93
report 1967-68, 208
Surgical firms, 441
Sutton, P. M. *Nature of cancer* (R), 66
Swimming Club : 154, 208, 264, 588
Blues, 519
U.H. Gala, 421
Symonds, Sir Charles (P), 183

T

Tanzania, medical help in, 579
Tatford, E. P. W. awarded M.B.E., 3
Taylor, Angela I, Romans were here (O), 304
Taylor, Florence. Compassion (C) 639
  Nurses' League, 260
  Uniform changes (C), 663
  Teaching on the wards (C), 70
Taylor, S. and others. *Short textbook of surgery* (R) 418
Teaching period (P), 347
Teeth, appeal for, 512
Television in teaching (C), 562
Theatre Club :
  Man for all seasons, 38 (C). 71
  notices, 14
  Recruiting officer, 414
  Ten little niggers, 132
Theft (C), 285
30 Club, 152, 338
Thomas, J. D. S. Obituary 441 (C), 513
Thoracic surgical research unit 1962-67 (E. Procter) (O), 558
Tihanyi, Anna-Maria. Primary aldosteronism (O), 502
Tomlyn, F. Obituary, 600
Toscanini, A. 486 (C), 514
Tower block scheme (C), 42, 88, (P), 127, 183, 349
Trewelyn, Margaret. No spoons (C), 91
Tripp, J. First and last (C), 226
Trounce, J. R. Guy's to R.S.M. (C), 613
Tuberculosis ; and the college (C), 562, 583, 614, 641
  Benjamin Marten and, 607
Tudgay, B. A. Those valleys (C), 44
Tunnadine, Prudence. Battered babies (C). 563
  Prudent (C), 257
Turner, L. J. Where there's smoke (C). 177

U

United Hospitals Rowing Club (C). 367
U Tun Aung—and dolls (C), 544

V

Vale, A. Let's go with (C), 308
Vale, J. A. Sex is but a link in a chain (C). 227
Verbal fireworks, 598
Vertue, H. St. H. Obituary 4, 26 (C). 42
Vietnam ; aid for (C). 514
  Dr. Evans in (C), 16, 176
Voluntary help at Guy's (A. L. Amsden) (O). 85

W

Wagner, Richard, 505
Wain, D. Dental mechanical students (C), 544
Wakeland, R. The point still missed (C), 335
Wales, (C), 16, 44
War ; how to win without actually killing (C. R. B. Joyce) (O), 217
War memorial arch (C), 42
Ward round, 313
Warner, F. S. Welcome to dental students, 561
Warner, Joseph (W. Hill) (O), 381
Warwick R. Communication at Guy's (C), 562
  Hallett Prize (C), 177
  High fees—low fees (C). 150
  Sembal Trust (C), 117
Water Polo :
  v. Battersea, 98
  v. Goldsmiths, 156
  v. Imperial college, 156
  v. London Hospital, 619, 646
  v. Old Midwhitgiftians, 591
  v. Q.E.C., 75
  v. St. Mary's, 98
  v. Shell, Lensbury, 519
  Knock-out competition, 291
  U.L.U. Knock-out, 670
  tour, 450
Watkin, R. consultant post, 427
Weaver, J. P. A. consultant post, 375
Week-ends (C), 17
Wengraf, A. Toscanini (C), 514
West, R. C. *Handbook for nurses* (R), 665
Westbury, D. G. A. consultant post, 158
Whaites, C. Flint followed Flint (C). 615
Wheeler, Mr. Dogs (P), 550
Whetnall, E. and Fry, D. B. *Deaf child* (R), 175
White coats (P), 241 (C), 255, 310, 286, 363, 392, 570
Whitney, J. consultant post, 550
Whuler, S. Cony (C), 69
William Gull ward, 322
Willis, J. consultant post, 427
Wills Library : (C), 613
  antiquities, 381, 410, 434, 484, 509, 539, 556, 580, 607, (C), 613, 636, 657
  bulletin (P), 101
  missing books (C), 640
  old books (P), 374
  theft (C), 489
Windsley, H. Hodgkin's grave, 656
Winner, H. I. and Hurley, R. *Symposia on candida infections* (R), 233
Women, ban on (M. A. Simpson) (O), 577 (C), 615
Wood, S. Residents' Play (C), 42
  Sold out-mini auditorium (C), 91
Words, S. Cameron (O), 129 (C), 228
Wotton, B. George Hayes (C), 334

Y

Yeager, M. E. *Review of operating room manual* (R), 175
Youth, (P), 569

GUY'S HOSPITAL GAZETTE

EDITOR D. S. ROBINS
NURSING CORRESPONDENT E. A. MALPAS

FORTNIGHTLY TWO SHILLINGS VOLUME 81 NUMBER 2047

PASSIM

Something of Value

In the last issue a diary extract made mention of the roving Yuletide band of Guy's minstrels, "The Niggers", who used to roam the hospital bringing tune and mirth to patients and staff in a television-free era. In more recent years this function has been performed in two sections, with a motley group touring the wards and the presentation of a Christmas Show, the latter most recently in the Physiology Theatre. This year, organisation of these entertainments seems to have faltered and to a certain extent drowned in a certain amount of cold water pouring, which, to say the least, is a pity. The hospital was a colder place without this frivolity, for however much the B.B.C. and I.T.A. may churn out aseptically over the holiday period, they cannot replace the spontaneity and closeness of entertainment in vivo.

Whoever was responsible for this great non-event we hope was at the hospital over the holiday period to see and hear how much these activities were missed. For the part of sentiment we might add that unless a more sympathetic and constructive attitude is adopted next year it seems that yet another tradition is dead. It would be well to remember the old Basuto proverb: "When a man does away with his customs and traditional way of life, he had first better be sure he has something of value to replace them."

Hospital Medicine

A short while ago, Sir Theodore Fox, in his "Crisis in Communication", bewailed as he informed us of the blastoma that is characterising medical literature. With the estimate of between six and nine thousand journals in existence, and the number increasing by two a week, not even the most spectacular rapid reading programmes can provide satisfactory succour for the doctor in his effort to keep abreast with the medical front lines. The place for a journal with good, comprehensive review articles is large, and recently a fair claim has been staked out by "Hospital Medicine". It has been greedy, leaving little room for others, but at the risk of being politically judged, may we, hopefully without monopoly, say "Welcome".

1966 and all that

As the dust settled over Christmas and the year slipped slowly through our fingers, it was time for retrospect, for stock-taking. Many people were sad, many complacent. Many more looked back with amazing lack of insight, if they looked back at all. But at Guy's there is no room for these sentiments and indifferences. They are unwanted and unworthy. 1966 at Guy's was, as ever, peppered with incidents, seldom historical but often embarrassing; incidents which should have stuck out in the memory like ripe apples on an Autumn tree, but instead were pushed beneath the surface to rot into non-existence, producing no effect at all.

Take, for example, the pleasure afforded us by seeing fifteen colleagues ride every storm to retrieve the Hospitals' Cup. Surely no one has forgotten this? But few will remember the trail of damage incurred by this triumph; a trail presumably believed to be an unavoidable legacy of the trophy which does nothing more than produce embarrassment and a sumptuous debt which is still to be met.

Many were surprised to see the Bar in the East Wing closed, and much was their horror on hearing that its glasses were to remain empty for the month surrounding Christmas and the New Year. Woeful, if not contemptuous, were the thirsty cries. Wilfully wounded is an institution? Possibly, the indifferent remained indifferent; probably the indulgent remained indulgent, for the neighbourhood is certainly well endowed with suitable replacements, but this is no excuse for abusing these facilities. Every student contributes financially to them and should be able to reap good, unhindered value therefrom. However, certain individuals apparently felt this should not be the case and proceeded to lose all physiological inhibitions with the subsequent reprimanding measures. Still, enough crying over spilt beer—please let them learn by these follies.

Certainly Christmas is almost forgotten, but for those at Guy's there was probably less to remember about this holiday than usual. But then, dust always settles quicker when it is dampened, and such was the fate of the recent seasonal activities.

Upsetting and disheartening as these misdemeanours and their repercussions may be, they were overshadowed by a chronic, crippling illness that gripped the hospital for yet another year. This illness is less specific than most seen on the wards and probably pathologically indefinable. Apathy is a disease prevelant in most student societies, not least medical, and unfortunately 1966 saw no advancement in the establishment of a cure. But since a cure must vary with the individual, it is clear that individual effort is required. Melodrama aside—can a crisis not be expected soon?

The picture is apparently painted of a gloomy 1966, but, in fact, it was no more remarkable than many others. However, this is no excuse for complacency but instead it should induce determination for improvements. Wave good-bye to it, therefore, with a sigh of relief and face this New Year with confidence and more thought.

R.E.C.

We continue to welcome the New Year with congratulations to Dr. Charles Baker and Miss Jean Bailey on their recent wedding. We sincerely hope that, as has been suggested, this will provide an excellent impetus to the movement to get married quarters for residents.

We congratulate Mr. E. P. W. Tatford on his award of the M.B.E. in the New Year Honours List.

With the prospects of higher pay in view, Dr. Michael D'Souza has regretfully decided to change his employer. His tireless enthusiasm and humour during the past year or so that he has devoted to the "Gazette" are our loss and his patients' gain. A new Assistant Editor will be appointed next month.

GAZETTE 1966 AWARDS

Liveliest Man of the Year—Mr. Bean*y.
Crisis-breaker of the Year—Dr. Carl*ton.
Sportsman of the Year—Dr. McGu*rk.
Sportswoman of the Year—Sister D*y.
Miniskirt of the Year Award—Dr. J. McL*od.
Best Dressed Man of the Year—Prof. Tro*nce.
Registrar of the Year—Dr. Ron Plateau.

Events

Greatest Non-Event of the Year—The Christmas Show.
Best Kept Secret of the Year—Dr. B*ker's Wedding.
Engagement of the Year—The "late" B. A. R*ss and Miss J. B*rridge.

Other

Co-operation Award, 1966—Theatre Sisters—yet again.
Specific Award—Dr. Gr*mble.

M.F.D

GUY'S DIARY

JANUARY

9th	M.	1.00	Clinical Lecture. Dr. BAKER. "Intensive Care after Myocardial Infarction."
10th	Tu.	1.00	Clinical Lecture. Dr. BISHOP. "The Endocrinology of Contraception."
12th	Th.	1.00	Clinical Lecture. Dr. HARDWICK. "Haematemesis."
		4.30	Physiological Society. Mr. B. WRIGHT. "Antarctica and Cold Acclimatisation."
16th	M.	1.00	Clinical Lecture. Dr. STAFFORD-CLARK. "Bond in Biochemistry: Drugs as Double Agents."
19th	Th.	1.00	Clinical Lecture. Mr. WASS. "The Surgery of Ulcerative Colitis."
		5.00	Neurosurgical Round. Mr. SCHURR. In Clinical Theatre.
20th	F.	1.00	Clinical Lecture. Dr. MACLEAN.

OBITUARIES

Dr. H. St. H. VERTUE

The following was printed in the "Gazette" in 1956 *on the retirement of Dr. Vertue from Guy's.*

Vertue came to Guy's from Oxford in 1914 and qualified in 1916. After serving as House Officer he joined the R.A.M.C. and went out to Palestine and, after Allenby's successful advance, finished up as Medical Officer of Health for Jerusalem. Returning to Guy's, he became Medical Registrar and Demonstrator of Pharmacology to Dr. Mutch from 1920 to 1924. He greatly admired Beddard, to whom he was Registrar, and from this admiration and from his imitations acquired some of his mannerisms.

In 1923 he became Medical Officer to Salomon's Centre and has held this post for more than thirty years. This decided the course of his medical work, for he became medical officer to other infant welfare centres. Here he was a stimulating teacher and his advice, based on robust common sense and a good knowledge of physiology, has been a great help to many generations of mothers. The timid rules often laid down by those without a wide enough knowledge of all aspects of the subject made little appeal to him, and he was well aware of the natural variability of children and their parents and was always ready to temper his advice to the particular situation in hand. Perhaps it is his love of Lucretius that gave Vertue a very "modern" approach to the care of infants.

During the war he returned to general medicine and became Physician at Orpington, where he has continued working. He helped the depleted staff with the medical teaching, and one can be sure that many of his remarks will be remembered by his students, for he has always been a born teacher covering a wide range in his remarks.

To readers of the *Gazette* it is hardly necessary to say much about him, for the *Gazette* has been fortunate, over the last few years, in having many articles in his lucid and individual style, with constant quotations from the classics and from English literature, and recently his articles on Orpington.

One cannot doubt his intense interest in children and their welfare, his love of beauty and—dare I say it—of Guy's nurses in particular, his love of good English and his castigation of much modern medical slang. His garden, his flowers and his cats have been equally dear if they have figured less in the pages of the *Gazette*.

It must be rare for anyone outside the professional masters of the Classics to have such a wide knowledge of Greek and Roman literature and to have continued to read these so widely and to make so much use of it in their writing and conversation. His paper in the *Guy's Hospital Reports* (1953) "An Enquiry into Venereal Disease in Greece and Rome" is likely to remain a standard work for there are few, if any, who combine his medical knowledge of the subject with his ability to quote and understand the contemporary authors who provide the evidence on the subject.

His conversation and his loud, cheerful laugh will be greatly missed in the Staff Common Room, though we hope that he will still often be seen there and in the Hospital.

J.M.H.C.

The sudden death of Dr. Vertue will be a grief to the many mothers and children of Southwark and Bermondsey, who regularly attended his Infant Welfare Clinic at Salomon's Centre.

Never has a doctor been so beloved by his patients or been treated so much as a Father Confessor as was Dr. Vertue, especially during the war years.

I was privileged to work with him at this period and witnessed the confidence with which he inspired these worried mothers. They spoke of him with very near reverence, and their children loved to come to see him.

His clinics, in which I worked for many years, were a joy with which to be connected, and Dr. Vertue was a gentleman of sterling worth.

L. COOMBE, S.R.N., S.C.M., H.V.

It is with deep regret that we have learned of the sudden death of Dr. Vertue.

Those of us who were with him at Orpington during and immediately after the war will always remember his great kindness to, and interest in, the nursing staff.

He was a prominent figure at the nurses' social events, and a most hospitable and charming host at the many tea parties at his home in Lower Road.

He took especial interest in the training of student nurses, and liked them to accompany him on his ward rounds in order to give them the benefit of his wide experience.

Our sympathy goes to his widow, who was for so many years his devoted companion.

R.T.

Many Guy's nurses will be sorry to hear of the death of Dr. Vertue. He died in Orpington Hospital, with which he had been associated since 1939. Dr. Vertue was a lecturer on medicine and medical nursing for a great many years. He was very popular, for he had a gift for establishing a happy, reciprocal relationship with the student nurses. His style was definite and clear and his writing on the blackboard could be read by the most myopic in the back row. He was a member of the Education Committee of the School of Nursing for a number of years and took great interest in all pertaining to nursing education. His fine physique and hearty laugh will be remembered for a long time. Nurses will wish to extend their sympathy to Mrs. Vertue, also a Guy's nurse.

FLORENCE TAYLOR
Late Principal Tutor
Guy's School of Nursing

Dr. T. A. MUNRO

Dr. T. A. Munro, formerly Physician in Psychological Medicine to Guy's Hospital and Director of the York Clinic from 1947 to 1954, died in Edinburgh on December 18th, 1966, aged sixty-one. He had left Guy's in 1954 to take up the appointment of Physician Superintendent to the Royal Edinburgh Hospital for Nervous and Mental Disorders, in succession to Sir David Henderson. At the time of his departure from Guy's the *Gazette* published an appreciation, from which this paragraph reflects the affection and esteem in which he was held by all who knew him here.

"In almost eight years his enthusiasm and unsparing services to Guy's have been marked by a greater development and extension of the clinical teaching of psychiatry in the Hospital than has been seen at any time in its previous history. With this has come an increasing integration of the work of the Department of Psychological Medicine with all the other clinical departments, together with the most welcome emergence of knowledge and interest in the subject, from the earlier and illusory seclusion of a special department, to the wide and broad front of medical teaching and work in the Hospital as a whole. Dr. Munro has consistently dedicated himself to bringing about that unity and friendly co-operation between psychiatry in a teaching hospital, and all the other aspects of medical and surgical endeavour, which was always the ideal pursued by Dr. Gillespie, to whose fame and kindly genius the establishment of the York Clinic at Guy's is a lasting memorial."

Dr. Munro will be remembered by all of us who knew him at Guy's as a deservedly eminent and particularly kind and gentle physician. He leaves a widow and one daughter to whom we would all wish to extend our heartfelt sympathy and sense of loss at this time.

D. S.-C.

Dr. R. H. FARRELL

I knew Ginger Farrell only at first in the role of a doctor who knew he was suffering from a fatal illness, and who was prepared out of the kindness, courage, and humility of his heart, to talk about what this meant to him, to students and the relatives of patients. Because of the remarkable integrity with which he dedicated himself to this unusual and challenging task, he was asked to contribute to a number of B.B.C. Sound and Television programmes, to which he brought charm and dignity as well as those other qualities of his personality to which tribute has justly been paid.

Ginger Farrell's distinguished war record as a R.A.F. pilot, his subsequent ambition to become a General Practitioner, and his discovery while still a student that he was suffering from multiple sclerosis, might seem simply to be elements in an irretrievable tragedy. It was his remarkable gift to make them seem exactly the opposite to those who were privileged to know him; to become a source of hope and inspiration for all who respect that element of human beings which can transcend their humanity and even their mortality. Having that gift, he gave of it, and of himself, generously and throughout his shortened life.

Our admiration and sympathy go out to his wife and children—and to his memory.

D. S.-C.

HENRY NOEL ST. JOHN, F.R.C.S., D.L.O.

Noel St. John died in Hammersmith Hospital, London, on November 23rd, 1966, aged 41 years.

In 1944 he crossed the Atlantic in a troop convoy, and became a student at Guy's, thus following the family tradition.

To his associates, Singe was a loyal and considerate friend who could share a joke with a considerable sense of humour.

Boxing and Cricket were his main sporting activities. He was a permanent member of the Hospital's cup winning sides between 1944 and 1950, and very rarely did he make it necessary for the referee to add up the points.

Matt Wells once said of him—"With my boxing brain on his shoulders he could be champion of the world."

After qualifying in 1950, Singe took a number of hospital appointments and obtained the D.L.O. in 1953 and F.R.C.S. at Edinburgh in 1959. He then specialised and became Ophthalmic Surgeon to Barbados General Hospital.,

We who knew him send our deepest sympathy to his family back home in Bridgetown.

W.M.S.

MEDICINE IN SOUTH WEST AFRICA

—with special reference to Pathology

by S. S. GROVé

A correspondent wrote a rather distressingly biased letter about South Africa in your columns recently, and having read this, it occurred to me that although South West Africa, where I live, might be well known in the international political sphere, few people outside the Republic of South Africa or South West Africa will know anything of its non-political affairs such as its medical services. As a Pathologist in the service of the South African Institute of Medical Research (S.A.I.M.R.) I am, in the main, concerned with all aspects of the medical services in this territory. I would like, therefore, to present an outline of some of these medical services provided for the people of South West Africa. Accounts by Guy's doctors and nurses practising in far-flung areas of the globe have always interested me very much. It is possible that others amongst Guy's men and women may be equally interested in the affairs of our part of the world.

South West Africa has a rather interesting and greatly differing indigenous population. They are the Namas, Bushmen, Hereros, Damaros, Okavangos, Ovambos and the Stone Age people of the Kaokoveld (North Western Territory), the Ovahimbas and Ovatjimbas. There are many facets of medicine and pathology amongst these various Bantu nations which need elucidation. Interesting and curious disease incidences, normal and abnormal biochemical and serological values as well as differing blood group patterns occur, to name only a few, which will take years of research to sort out.

The State Health Service—rendered by the S.W.A. Administration. This service is headed by a Director who is assisted by two Deputy Directors. Of the latter one is concerned mainly with curative and the other mainly with preventive health services.

There are, in this Territory, State and Mission hospitals for white and non-white patients who receive free treatment. The State hospitals

are also open to paying patients who desire to be treated there by their private practitioners. All these hospitals and their activities fall under the jurisdiction of the health section concerned with curative services. Mission hospitals throughout South West Africa serving non-whites are subsidised by the State to the tune of one hundred per cent of their expense account, including capital expenditure. This includes the salaries of Missionary doctors and nurses. Specialist medical men are flown monthly if needed, to the Northern Bantu Territory where consultations and operating sessions are arranged for them on complicated cases. Ovambo patients are transported from far and wide over this part of the country to receive specialist attention during these visits, and the Mission hospitals generally make use of these facilities freely. Provision is made for flying very ill Bantu patients to Windhoek when the circumstances demand urgent treatment in a specialist institution by specialists.

An indication of annual hospital attendance at State and Mission hospitals as well as clinics in the Northern Bantu Territories, is reflected in the figures below. The figures given for Windhoek are an indication of the position in the Southern part of the country where both white and non-white reside.

Northern Bantu Territories (1964):

1. Ovamboland (population 240,000):

No. of in-patients	18,298
No. of out-patient attendances	807,202
Calculated patient days	487.418

2. Okavango (population 28,000):

No. of in-patients	8,793
No. of out-patient attendances	174,282
Calculated patient days	338,126

Southern S.W.A. (1965):

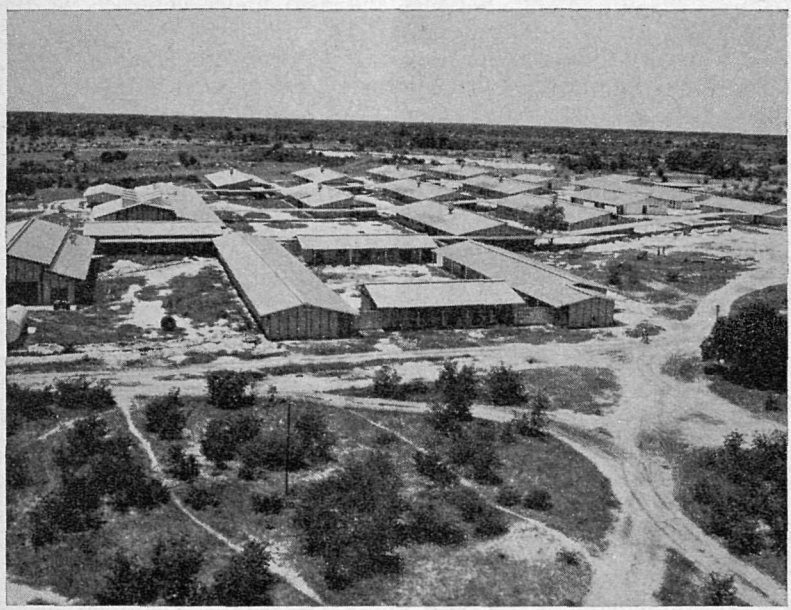
Windhoek (population: white 26,000, non-white 25,000):

No. of (white) paying in-patients	2,676
No. of (white) non-paying in-patients	639
No. of (non-European) in-patients	4,286
No. of (white) paying out-patient attendances ...	2,939
No. of (white) non-paying out-patient attendances	4,085
No. of (non-white) out-patient attendances ...	48,800
Calculated no. of patient days for whites	37,549
Calculated no. of patient days for non-whites ...	98,999

The Windhoek figures do not include data for psychiatric and tuberculosis patients, nor does it, of course, include private doctors' patients treated at surgeries and private hospitals. In some areas along our very extensive borders the reputation of the S.W.A's. medical amenities results in the fact that 50 per cent or more of the patients treated in these hospitals, are citizens of a neighbouring country. (The figures given above should be read with this in mind.) As some large non-white hospitals are situated near the borders, this amounts to a large number of foreign people treated free of charge every year. It is the firm policy of the Administration of South West Africa to treat all Bantu who come, irrespective of their country of origin. An interesting result of this policy is that even the lepers

sometimes walk for many hundreds of miles from bordering countries to seek admission to our leper colony! All hospitals planned in certain places near our borders are so designed as to make provision for the expected attendance of foreign patients.

The large Ovamboland State hospital is staffed by keen and competent doctors who render an admirable service away from their own community in what is in many ways to them a strange country populated by a pastoral and still primitive people. In some ways their service, without the additional stimulus of religious fervour, is to me even more laudable than that of the Missionary doctors who work there. This does not mean that I wish to belittle the work of the latter. The task they have accomplished over years of service to their Churches and the people of South West Africa cannot be measured by any standards whatever. South West Africa acknowledges this fact in supplying all the money they need to carry on their great work amongst the sick of the country.



View of the 400-Bed State Hospital at Oshakati, Ovamboland.

Preventive medical services in South West Africa have made their finest contribution to the Territory's health in those areas where malaria, plague, bilharzia and tuberculosis have posed the biggest problems, i.e., our Northern Bantu Territories. Experts from this

country and overseas have tackled the problem with vigour and the measures taken to combat some of these diseases have proved in many instances to have been entirely successful, or as successful as one can expect them to be anywhere in the world. Intensive research undertakings were invariably succeeded by active preventive and curative measures to control these diseases. The result has been a sterling achievement for all those concerned in the campaigns to wipe out or diminish the incidence of problem diseases such as those mentioned above. Not the least credit goes to the people of the areas where the wholehearted co-operation in a primitive community such as Ovamboland is a triumph over superstition and a testimony of trust in the goodwill of the authorities concerned with their physical well-being.

PATHOLOGY

The South African Institute for Medical Research (S.A.I.M.R.) in the Republic of South Africa provides an extensive laboratory service for private patients and for the patients of the Provincial and Central Governments. In South West Africa it undertakes laboratory investigations for private patients and also under contract for the South West Africa Administration. The profits of the Institute so derived from all these routine laboratory services throughout its sphere of activities are ploughed back into the extensive medical research programmes of this organisation. No person is ever denied the facilities of the S.A.I.M.R's. laboratory services and therefore a great deal of the laboratory work is carried out free of charge for those who cannot afford extensive and costly laboratory tests but who do not qualify as free State patients. All Coloured and Bantu patients, irrespective of income, are entitled to have all laboratory tests required by Medical Officers of the Administration carried out on the latter's account. This means that they are entitled to have an unlimited number of tests without any cost to themselves if the doctor requires these to be done. The S.A.I.M.R. consequently does the greatest number and the most extensive range of tests for the Administration of South West Africa's Health Department. The white State patients who qualify for free laboratory investigations probably account for only a few per cent of the work done by the S.A.I.M.R.

Windhoek, the capital of the Territory, has a big central laboratory with a pathologist in charge and a staff of eighteen technologists of whom six are fully trained. This laboratory provides, at present, a service for the whole of South West Africa with the exception of Ovamboland, a Northern Bantu Territory.

Windhoek laboratory: provides a comprehensive laboratory service, including histopathology, chemical pathology, microbiology, haematology and serology. A virus laboratory is at present being planned. All specimens (with the exception of those from Ovamboland) are submitted for examination to Windhoek from throughout this vast country. Specimens arrive by rail, road and air and in many instances a reasonably satisfactory laboratory service can be offered to outlying places. Other smaller centres at present not in easy reach of laboratory services will, with present planning, soon be served more adequately with regard to pathological investigations.

The Ovamboland branch laboratory of the S.A.I.M.R. is situated at a place called Oshakati and provides all the routine pathological procedures for this country with the exception of histopathology. The laboratory has a trained and experienced Coloured technologist in charge in addition to four Ovambos in training. Two of the latter have undergone preliminary training at the Windhoek laboratory for more than a year and have now reached an advanced stage of technological skill. They will qualify as medical technologists after completing the National Examinations in Medical Laboratory Technology of the Department of Education, Arts and Science. When so qualified, they will take charge of the technical aspect of the laboratories in their country and the Coloured technologist will then return to Windhoek. Oshakati laboratory serves the large Oshakati State hospital, an Anglican, several Roman Catholic and Finnish Lutheran hospitals as well as numerous peripheral clinics. The laboratory is used also from time to time by medical research teams visiting Ovamboland. All histological specimens are dispatched to the Central Laboratory at Windhoek regularly by means of very frequent road or air transport and laboratory reports, if not urgent, are delivered to hospitals in Ovamboland by any form of transport immediately available. In cases of urgency, reports are telephoned or wired.

The Bantu in South West Africa have not yet reached that stage where they voluntarily donate blood for transfusion purposes. The S.A.I.M.R. in Johannesburg pays its non-white donors and consequently gets as much blood as it needs from them. Blood is delivered by air approximately twice monthly from the S.A.I.M.R. Central Laboratory in Johannesburg to Windhoek, from where it travels again by air to the Oshakati laboratory in Ovamboland. The total cost per pint to the Administration of South West Africa (including air freight) is £2 12s. 6d.! This blood is cross-matched at the Oshakati laboratory and is also distributed from there to the various Mission hospitals according to their individual needs. At present, the white donors of Windhoek and other towns in South West Africa supply all the blood for white and non-white throughout the territory, Ovamboland excepted of course. The non-whites require by far the lion's share of blood collected by this all-white donor service. Because of various difficulties, a stable voluntary transfusion service using Bantu and Coloured donors, has not yet been possible up to the present time here in South West Africa. Such a service is envisaged for the future.

I visit Ovamboland once or so per month to deal with the administrative and technical matters of the laboratory there, but have, of course, to procure a permit (pass one could call it), valid for a restricted period only, to enter this Bantu Territory. I may add that I am allowed, as well as all whites are, to render essential services in these native territories, but that I or any white man may never own land in that region nor any of us start a business there. This seems fair especially as the Ovambos are being trained and encouraged to develop their own commercial undertakings. The region has always belonged exclusively to the Ovambos and will continue, we hope.

to belong to them alone. With this in mind the people of Ovamboland are guided towards responsible self-government by the authorities in a manner adapted to the Ovambos' way of life. The development of their country is still, however, largely dependent on the Administration of S.W.A., both technically and financially at this stage.

Future Plans: Next year, the large Bantu Territory to the north-east, the Okavango, will get its own laboratory which will be attached to the new State hospital now nearing completion at Runtu. A new leper hospital further up-river is also being built. The proposed new branch laboratory of the S.A.I.M.R. in Runtu will also be staffed by a trained Coloured technologist and other learner Coloured technologists now in training in Windhoek until such time as the Okavangos are capable of running this service themselves. As from next year, several Finnish, Lutheran and Roman Catholic Mission hospitals in the Okavango will share in the facilities of a modern routine diagnostic laboratory, which will be situated within their reach.

Each of the Mission hospitals in the Okavango will send one of their Bantu staff early next year to undergo a three months course in side-room laboratory work, i.e. basic haematology, microscopical and chemical examination of urine, C.S.F. cell counts and Gram staining of C.S.F. (and other) smears and stool parasitology. In addition they will learn how to treat and dispatch laboratory specimens for examination elsewhere. The recognition of malarial and other parasites in blood smears and the examination of urine and stools for schistosomiasis is also included in this course. The Ovamboland Mission hospitals have laboratory-aids, trained in Windhoek some time ago by the S.A.I.M.R. at the request of the S.W.A. Administration, now doing this type of work. The function is in the main one of giving assistance by means of simple but very necessary tests, to the Mission doctors. Several other centres in South West Africa serving both white and non-white populations are scheduled to have laboratories within the next year or so. Because our country is big, and by Britain's standards sparsely populated, we are forced to decentralize our laboratory services. The extent and volume of laboratory work done is, I believe, large when one considers that one pathologist has charge of it all, but pathologists here in Southern Africa are, like I presume elsewhere in the world, in very short supply.

At the risk of once more provoking the *Gazette* correspondent mentioned at the outset of this article, I cannot restrain myself from reiterating the words which he so violently attacked: "a land of promise"—South West Africa is just that for all of us who live here. There are many opportunities here for us to develop, to expand, to teach, to learn, to improve, to work, to assist and above all to serve our country and the profession we have chosen. The success of our service will be determined by our convictions, our skills, our temperaments and, last but not least, our consciences. I doubt if we could be found wanting when compared with standards elsewhere in the world.

THE HOPKINS PRIZE FOR BIOCHEMISTRY

Sir Frederick Gowland Hopkins, O.M., P.R.S., sometimes called "the father of British biochemistry" was, of course, a Guy's man. He came here in 1882 as a laboratory assistant to Dr. (afterwards Sir) Thomas Stevenson, Medical Jurist. Hopkins was befriended by John Wade, an assistant who afterwards became chemistry lecturer and author of a textbook of organic chemistry (we still have some of his extensive library). In 1882 Hopkins took the External B.Sc. of London University and in the following year, at the age of 27 and whilst still working at Guy's, became a medical student. He was at once awarded the Gull Research Studentship, as its first holder. He won a gold medal in chemistry and materia medica for his preclinical studies. In the clinical period, he was dresser to Charters Symonds and Davies Colley, and ward clerk to Newton Pitt and Hale White. He writes: "I received much encouragement and subsequent friendship from my clinical teachers." He became a demonstrator in practical physiology in the early days of Starling's appointment as lecturer. He also taught 1st M.B. students in physics and chemistry. Hopkins particularly valued his appointment as Clinical Assistant: the "Clinicals" were a privileged group of students having considerable latitude in the selection of cases for treatment.

In 1894, Hopkins qualified Conjoint and M.B., London. In his last years at Guy's, he edited the *Gazette*, and because of his interest in the "pathologist's column", which published reports on specimens sent in by Guy's practitioners, started the Chemical Research Association which had a highly successful life as a pathological service. In 1898 Hopkins left Guy's for Cambridge and the glories of his subsequent career.

Despite Sherlock Holmes, not all medical students share Hopkins' interest in chemistry; nevertheless, the teaching of biochemistry in London medical schools has greatly increased in recent years. The Academic Diploma of this University was established three years ago; Guy's has already entered 9 candidates and obtained 9 passes, with 5 Distinctions. Six students are now attending the course. In 1968, under the new Regulations of the University, a B.Sc. can be awarded on what will be virtually the present Diploma course. Next year also, the 2nd M.B. Examination will have Biochemistry as a separate subject, of equal standing with Anatomy and Physiology.

These events have led the Medical School to the decision to offer an annual Prize in Biochemistry, to be called "The Hopkins Prize". Its present value is to be £25. It will be open to preclinical students, with no previous qualifications in biochemistry, in their fifth term at Guy's. For the present, it is intended that the Prize shall be awarded on the results of a special written paper and oral examination, held at some time before the 2nd M.B. Examination in March. The first award will, if merit allows, be made in 1967. Judging by current form in the class of students concerned, competition is likely to be keen.

G. A. D. HASLEWOOD.

NOTICES

Guy's Hospital Theatre Club

It is within minutes of the final curtain of each production that the Theatre Club begin to think on the next production. As always, the first and major question concerns the identity of the producer and, as usual, the questioners are temporarily satisfied by the promise of a notice in the *Gazette*, advertising this post.

Such is this notice. It is entered with dutiful repetition and, unless the *Gazette's* public has changed, will be received with dutiful indifference. Bring your Theatre Club some new year joy and think on the possibility of producing the next production and the immense satisfaction and praise accorded you by so doing. The task is certainly big but not monumental, but if you think even that is too much, then feel free to help in some other way. Should you feel equipped to accept the challenge, however, please inform Mr. Peter Davenport of your interest, as soon as possible.

Rugby Club Ball

The Annual Rugby Club Ball will be held this year on Thursday, March 16th, at Quaglino's, Bury Street, St. James', S.W.1. Tickets 4½ guineas (students), 5 guineas (qualified) will be available from the end of January and may be obtained from W. W. Davies, J. G. Payne and B. J. Rowlands.

BALL SECRETARY.

CORRESPONDENCE

Hearts in other places?

SIR,—I write in the belief that some Guy's men will wish to know more facts about the subject referred to by Passim (December 10th) under the title "Hearts in other places?"

The principal point at issue is the problem of congenital heart disease presenting in infants (in practice the first six months of life include the great majority of deaths). About six infants in every thousand live births have congenital heart disease, of these about 40% are dead by the age of two years. Therefore, about 5,500 infants are born with heart disease each year in the United Kingdom, and more than 1,500 will die in the first year of life, many with conditions which could be successfully corrected, given optimum present day facilities.

How many infants are operated on for heart disease in this country? A few hundred at most. At this hospital, slightly more than 100 under one year of age were operated on in 1965. In the remainder of the London hospitals the total number of infants operated on for heart disease was slightly less than 100, and there are only a few other centres in the United Kingdom where this surgery is regularly performed. There is therefore good evidence that many infants die of untreated heart disease in this (and in other) countries, whose death could be avoided. These facts are available to anyone working in the field of infant heart disease, and to deny them is to show ignorance of an important problem in paediatrics.

Of those children who are referred for treatment, the mortality rate is still unacceptably high in some cases in this hospital as in others. In an effort to lower our own mortality rate we have approached official and private authorities for support for laboratory and clinical research. Equipment and staff will require several hundred thousands of pounds in the next few years. A large unit is essential for both economic and academic reasons. The staff for patient care must be numerous and special experience is essential for nurses, resident medical

staff, anaesthetics, cardiologists, etc. The British Heart Foundation are supporting the development of research work at this and other hospitals. The success of their appeal is vital to the development of heart surgery in infants in this country, because the Ministry of Health, while being aware of the urgent needs and doing all in their power towards a solution, do not have enough funds for research in addition to patient care. Too few of the well-endowed London teaching hospitals have been prepared to support units large enough to contribute to the care of a significant number of these infants.

The British Heart Foundation launched their appeal for infant heart surgery at a Press conference held at this hospital. Of some thousands of lines reporting this there was one which perhaps needed qualification. Enclosed is a copy of a letter sent by us to *The Guardian,* December 2nd, which remains unpublished.

Is it seriously contended at Guy's that it is shameful to refer patients to another institution? We frequently refer patients to other centres both in and outside London, often because the other centre has some special experience or facility, and this referral has always been welcomed by parents, when explained to them. (Incidentally we try to know of the special strengths of other units so we can advise our patients to their best advantage). Many other centres also refer certain types of cases to this hospital, but no cardiologist or cardiac surgeon could pretend that any single centre is the best for all patients.

It seems especially sad to me that a hospital which has housed the greatest of British cardiac surgeons, and which has produced so much important progress in cardiac surgery and in cardiology, should be associated with an attack on the good name of another London hospital and which may retard the development of infant cardiology, without ascertaining the facts of the matter in dispute.

Yours, etc.,
EOIN ABERDEEN, F.R.C.S., D.C.H.,
Consultant Thoracic Surgeon.

The Hospital for Sick Children,
Great Ormond Street,
London, W.C.1.

[We are glad to print the above letter, as it underlies the need for better services for children with congenital heart disease. The last paragraph puzzles us. *Passim* on this topic dealt with the Press reports which had implied that there is only one centre (at the Hospital for Sick Children) for surgical treatment of congenital heart disease. We have re-read the letter to the *Guardian* from this hospital; it corrected misleading implications or statements that had appeared, and it ended with a reference to the good work done at the Hospital for Sick Children. We find in that *Passim* no basis for the suggestion that it is not considered proper at Guy's to obtain help from other places. We were glad to see Mr. David Waterston (of Mr. Aberdeen's hospital) recently visiting Diplock to see a patient admitted under Dr. Mac Keith. The parents and Dr. Mac Keith are certainly grateful to Mr. Waterston for his kindness in agreeing to take the child into his hospital. Nor is this by any means the only kindness Guy's has had in 1966 from that hospital. In the reverse direction a research worker from Guy's has been visiting Great Ormond Street to help one of their research teams. The co-operation will continue because it is to the benefit of patients.—ED.]

Miss G. Saint

SIR,—Miss G. Saint, Superintendent Health Visitor at Salomon's Centre, has been appointed a Principal Nursing Officer in Newcastle and has just recently left Guy's.

Miss Saint has been at Guy's for five years since she succeeded Miss Coomb. She has kept the Centre an outstandingly good one. Her Mothers' Discussion Club now runs itself, inviting its speakers, and it will continue even though the initiator has gone elsewhere.

The *Gazette* on 4th September, 1965, contained an article by Miss Saint on "The work of the Child Welfare Clinics" which was described in the B.M.J. as the most important article written on this topic in recent years. In this, Miss Saint showed the breadth of vision with which she ran the work down at Solomon's Centre for mothers and children who live near Guy's. They will miss her very much.

Yours, etc.,

R. C. MAC KEITH.

Guy's Hospital, S.E.1.

Dr. Evans in Vietnam

SIR,—On behalf of all doctors who have spent a period working in undeveloped countries, I would like to applaud Dr. Philip Evans' action in leading a team to South Vietnam.

Quite apart from the obvious benefit to the children of Saigon, his action has conferred the seal of official approval upon such work, which has up to now been considered eccentric and outside the proper practice of medicine.

I suspect that Dr. Evans will find such work enormous fun.

Yours, etc.,

COLIN SMITH

Higham,
Rochester, Kent.

Palm and Finger Prints

SIR,—Professor Polani, of the Paediatric Research Unit, is interested in obtaining a series of palm and finger prints from normal individuals for comparison with those from patients with Down's Syndrome and other chromosomal abnormalities.

Volunteers, both male and female, from among the students and nurses, are invited to take part in the study by supplying their palm and finger prints; they may remain anonymous if they wish.

Those interested should please apply to me at the Paediatric Research Unit, Cameron House, between 10 a.m. and 5 p.m., Monday to Friday.

Yours, etc.,

CHRISTINE GARRETT.

Still in the Valleys

SIR,—In that sophisticated town called Brighton, where I once practised for several years, a patient from a working-class street once said to me in withering tones about his next-door neighbour: "He has never been further than his back yard." One assumes that Dr. Tudgay has at least been as far as Guy's, unless he somehow qualified by means of a Correspondence Course. One always understood that travel broadens the mind, and there is surely enough travel taking place today even from back street. Even so, we have our racialists, with their racialism extended even to those living within their own country.

Perhaps it is expecting too much of people of this sort to have read very much, or even perhaps to have heard of that famous statesman of the 18th century—Edmund Burke. Was it not he who said: "You cannot indict a whole nation"? Whatever the Englishman may think of it, members of the small nations are the backbone of this country, and one has only to note the frequency of Welsh names in the Legislature and Judicature of this country today to realise this. No doubt this irks people of the Dr. Tudgay type. One remembers a letter of Dr. Tudgay's to the *Gazette* a year or more ago in which he made the egregious statement that those people who had qualified some years before he did must have forgotten all they had ever learned. When I first qualified I seem to remember having some superior views as to my up-to-date knowledge compared with any middle-aged or elderly doctors whom I happened to meet. I have long since, however, learnt the virtues of humility. *Experientia docet.*

For his recent ill-mannered letter to the *Gazette* Dr. Tudgay has been let off too lightly. One correspondent trounced him in the first half of his letter, and then invited him for a drink. After reading Dr. Tudgay's recent effusion no Welshman should want to be at the end of the same barge-pole with him, let alone the same bar.

Yours, etc.,

G. L. DAVIES

Oakfield,
Hay-on-Wye,
Hereford.

No Ancilliaries

SIR,—The short answer to the remarks of Mr. Peacock, secretary of the British Dental Association, is that it was necessary for some of us to move a motion at the Nottingham A.G.M. to stop the introduction of a category of B.D.A. membership for these New Cross ancilliaries.

Those of us who remember only too well the frequent outbursts from prominent B.D.A. men of the need and desirability to welcome these girls into the Association at that period, can be forgiven our misgivings now.

Mr. Peacock is just as aware as I that the stringent physical supervision as laid down by the Act is proving nigh impossible in many clinics.

Will Mr. Peacock give an assurance on behalf of the B.D.A. that any attempt to allow these girls to work unsupervised, to increase their scope of work, or even to recruit men to eventually work on adults, will be resolutely fought?

Yours, etc.,

L. B. LUX.

Strathyre, Warwick Road,
Hale, Cheshire.

Still Changing

SIR,—I was agreeably surprised to see my recent letter to you in print. My shape changing is as difficult to believe as is the legendary Indian rope trick, as the credulity gap is nearly 5ft. I must hasten to add that I should have stated that this changing occurs fully clad (this is not the climate for nudity except yeti or leprechauns). You might ascertain whether there are any other sufferers from this complaint, possibly a side effect from chemicals in food, drink, drugs, medicines, or perhaps flying saucer crews possessing human bodies when arriving at earth stations. What a fascinating science fiction investigation this would be. Imagine my meeting and marrying another female shape changer (of the contrary type). She would be 5ft. when I am 8ft., and I would be 5ft. when she would be 8ft. You might publish this letter to counteract any idea that I was not serious in my previous letter.

Yours, etc.,

JAMES G. DOUGLAS.

Manor Cottage, Mill Road,
Banningham, Aylsham, Norfolk.

Ending the Weak End

SIR,—I am sure the Bishop of Southwark would be interested to read your editorial in which you so categorically establish the supremacy of medicine over religion. I well remember a sermon of his in which he portrayed Moses as the first Trade Union Leader, leading the Israelite bricklayer tribe against the Egyptians in protest against the long working hours. You, I am sure, would have been one of the Pharoahs and gone down gurgling into the Red sea.

Bishop Stockwood saw the incident as a mix-up of politics and religion. You have sorted out which is the more important. Just two questions. First, if the Jews really are the chosen people and even they need a day of rest, how on earth are the rest of the ordinary mortals going to get by without it? And secondly, what happens to the dirty weekend?

Yours, etc.,

NICHOLAS M. COHEN

NURSING SECTION

Nursing Examination Failures

The majority of the nursing community of this country was amazed to learn that the results of the October examinations showed that one-third of all the students who entered for the finals of the General Nursing Council for England and Wales—failed.

There have been a number of reasons put forward for these failures. The main argument that has been agreed upon is that there is a lack of co-ordination between the practical and theoretical teachings that the student nurses receive.

The pass mark has remained the same but the method of assessing the practical examinations has been altered. The figures do not show in which aspects of the examinations the nurses failed, but there have been indications that the majority failed in their practical examinations.

It would appear that these practical failures must stem from the lack of teaching and supervision in the wards. It is true that the nurses' hours on duty are greatly reduced and nurses are encouraged to forget the single-minded devotion they used to have, and to gain outside interests. In some cases nurses are even taking jobs to supplement their working hours and salaries. However, while on duty in the wards there are two main sources of teaching—the Ward Sisters and the Clinical Instructors. The Ward Sisters are generally so busy that they have no time either to teach the nurses or to supervise their clinical work. The Clinical Instructors are a group of experienced nurses who do not have the recognition which is necessary to give them either the authority in the way of registration, or the encouragement to take up Clinical Instruction.

It has been said that the youth and inexperience of the Ward Sisters makes it difficult for them to exercise their responsibilities for training the student nurses. An answer to this inference is to point out that no hospital nursing administrator is going to appoint any Ward Sister who is incapable of carrying out her full responsibilities unless she has the full qualifications of experience and maturity despite her age.

There is no reason why the cause for the failures should not lie with the student nurses themselves. There are few nurses who attempt to supplement their ward observations and experience with their theory and books. Is this due to the fact that nurses have no incentive to work any extra time, or to the fact that the theory taught in the classroom is so divorced from the practical?

There may be something to be said for the fact that students are so spoonfed during their introductory course that they are unable during the rest of their training to use their common sense or to show any incentive to supplement their laid-down training. Maybe the type of teaching they receive does not encourage any nurse in training to do any more than the absolute minimum of independent studying necessary to cover the syllabus.

STAFF CHANGES AND APPOINTMENTS

APPOINTMENTS

Sister J. Parry (returning from 1 year study leave, Johns Hopkins Hospital), to Nuffield D. Floor.

S/N M. E. Davis (Guy's 1961-65), to Casualty.

S/M G. Nwdoili, to Victoria Ward.

S/M A. Phillips (Royal Free Hospital), to Victoria Ward.

S/N E. Potter (Guy's 1961-64), to Nuffield House.

S/N L. Pullen (Whangarei Base Hospital, Northland, New Zealand), to Casualty.

S/N J. M. Waters (Guy's 1962-66), to Cornelius Ward.

S/M B. Wears (Guy's 1963-66), to Victoria Ward.

S/M A. Yorke (Guy's 1963-66), to Victoria Ward.

CHANGES

Sister F. Abbott, from Caleb and Diplock Wards to Evelina Children's Hospital.

DEPARTURES

S/N J. Baillie, from Patience Ward.

S/N H. Barry, from Esther Ward.

S/M C. Clark, from Victoria Ward.

S/N S. Gray, from Diplock Ward.

S/N V. Moffatt, from Queen Ward.

S/N E. Lampitt, from Martha Ward.

S/N E. Rowley, from Sarah Ward.

S/N A. Stewart, from Nuffield B. Floor.

S/N S. Waddingham, from Caleb Ward.

S/N E. Wood, from Diplock Ward.

S/N C. Young, from Naaman Ward.

SPORT

RUGBY FOOTBALL

Have we done enough? With the New Year comes speculation as regards our chances of winning the Hospitals' Cup. But do we really have our priorities correct?

The Hospitals' Cup as it indicates is a select competition which naturally, therefore, brings prestige to the hospital, but its importance is only paramount to the small group of London Teaching Hospitals. What, in fact, is its effect upon the Rugby Club of Guy's? And, in fact, to the rest of the Rugger world?

Undoubtedly it boosts morale of the 1st team and perhaps they can be consoled that they have had a good season. We should not hesitate to congratulate and praise them for again being "Conquerors". But just for a moment, review the rest of the season. They have been successful against Cheltenham, Bedford, United Services Portsmouth, and very narrowly defeated against Cambridge. Surely these results overshadow the Cup.

And yet, this season, we are in the unhappy position of vacant fixtures. Richmond, Rosslyn Park and Aberavon are no longer regular fixtures. We need to fill them. Formal approach to other clubs has been fruitless. So, gentlemen, we need the influence of evey past and present member of the Club.

It seems futile to see last season's success being so admirably continued and improved upon this year and yet losing fixtures that even the other hospitals have!

Be progressive and sell the success of the Club. We need fixtures for future years. Can we rely on the Club members?

VACANT FIXTURES:
November 12th, 19th.
January 7th.
February 11th.

Following C. Thorburn's appearance in the Final Scottish Rugby Trial on Saturday, December 31st, we eagerly await news of his selection to play in Paris, especially with doubt surrounding the fitness of P. Fisher, the present Scotland captain.

DIARY

RUGBY FOOTBALL, 1967.

Jan. 14.—Plymouth Albion. Home.
,, 21.—Taunton. Away.
,, 28.—Devonport Services. Away.
Feb. 4.—Coventry. Away.
,, 11.—
,, 18.—London Irish. Home.
,, 25.—Exeter (11 a.m.). Home.
Mar. 4.—Old Alleynians. Home.
,, 11.—Nuneaton. Home.
,, 18.—Gloucester. Away.
,, 25.—Cambridge City. Home.
Apr. 1.—Old Whitgiftians. Away.
,, 8.—Tredegar. Home.

UNITED HOSPITALS CUP.
Jan. 17.—St. Mary's v. Guy's (2nd Round).

HOCKEY.
Jan. 14.—Romford. Home.
,, 21.—Tulse Hill 2nd XI. Home.

LADIES' HOCKEY.
Jan. 21.—Royal Holloway College. Home.

CROSS-COUNTRY.
Jan. 18.—4th Leg. Div. I. Petersham.
Div. II. Hale End.

RUGBY

GUY'S v. OLD CRANLEIGHANS

At H.O.P. 10th December, 1966

Result: won 22—0

People who watch rugby regularly often see very good tries scored, but only rarely can a try be seen which can be called truly magnificent. However, the spectators who watched Guy's defeat Old Cranleighans by two goals, two tries and two penalty goals to nil on a crisp, bright December afternoon, saw as fine a try as can be seen in any game of rugby anywhere. Considering the fact that the ground was like a mud bath after recent heavy rain, only makes the try more remarkable.

The try came mid-way through the second half, with Guy's leading 14—0. Elliott fielded a ball on his "twenty-five" and, instead of kicking for touch, passed inside to Thorburn who made a few yards before passing onto Beacham. He ran about thirty yards, evaded two tackles before passing onto Sharp, who passed onto Ross. The latter looked certain to be pushed into touch, but thinking quickly flicked it inside to Rowlands who passed onto Moore. Moore dodged through two opponents before passing to Hey, who scored half-way out for a magnificent try. Elliott converted. The whole movement was over so quickly that some members of the team who participated may have been omitted. Also because of the mud most players were by now unrecognisable—apologies to anybody forgotten!

As far as the rest of the game was concerned, Guy's were in fine fettle and considering the frightful conditions underfoot their handling was well above average. The Old Cranleighans, who included David Hartley, a Guy's student, were somewhat outclassed in skill but made up for this by great enthusiasm. Their three-quarters had little or no chance to show their mettle, and most of their attacks came from occasional foot rushes by their forwards.

In the first half Guy's were able to score an early try, mainly due to backing up of the forwards. It is their loose play this season which has improved so much and their results are ample proof what a difference good loose balls make. As the game wore on Guy's were getting more on top, with Rowlands making some fine kicks to his wings and for touch. The Guy's back row were quite splendid, both in defence and attack. Guy's certainly have an absolute wealth of talent in back-row forwards.

By half-time, Guy's had added a penalty for a scrum infringement and a try by Beacham. This was a fine individualist try earned by sheer persistence. Elliott converted to give Guy's an 11—0 lead at the interval.

In the second half Guy's were even more on top, and apart from their wonder try, scored a penalty after Rowlands was obstructed, and Rowlands scored Guy's fourth and final try by going round the blind side following a set scrum near the Old Cranleighans line.

Guy's were on top in all departments throughout the whole game. However, credit must be given to both sides for trying to keep the game open in such difficult conditions.

Guy's: D. R. Elliott; J. Price, R. J. Beacham, D. J. Osborne, J. R. M. Ross; B. J. Rowlands, B. W. R. Moore; J. E. Davies, G. B. Hey, A. J. Kingdon, J. M. Cockburn, R. A. C. Hughes, K. G. E. Brown, H. C. Sharp, C. W. Thorburn (Capt.).

G. E. RATCLIFFE

GUY'S v. ESHER

At Hersham Saturday, 17th December, 1966

Result: won 11—3

Guy's, playing into the wind, started off with a strong attack. Within two minutes Esher were penalised for off-side at the line-out. Elliott just failed with the kick. Esher counter attacked and scored three points when Hey was penalised for foot-up in the scrum 25 yards out. Esher continued to attack and their inside-centre attempted a drop-goal, missing by two yards. The play was generally scrappy, with Guy's playing in lackadaisical fashion. However, the last ten minutes of the half produced some sustained play by Guy's; by good tackling and covering Guy's gradually went up to the Esher line. Barford was tackled into touch after a good movement by the threequarters. Soon after Thorburn made a break from the back of the line-out, Moore backed up and passed to Price, who was tackled ten yards from the line. From the loose-maul the ball went back along the threequarters where Osborne was brought down trying to make the half-break. Thorburn picked up and passed to Rowlands who went over in the left corner. Elliott hit the post trying to convert.

Some hard talking at half-time produced a more purposeful Guy's team. The loose play was more powerful, and rucking was much better, while the backs tried more individually, and "drew their man" rather than wastefully passing out to the wing, who had no room to move. At the line-out more blocking and better jumping and catching allowed better possession and more room for Moore to work in.

Almost immediately Price came into the line inside Rowlands and made 30 yards before the full-back brought him down, and the attack fizzled out in a loose scrum. When an Esher clearing kick failed, Elliott attempted a drop-goal which hit the base of the post, Sharp caught the rebound and was held up on the line, a lucky fly-hack saved Esher. This remained the pattern of the second half, with Guy's failing to score through not seeing the opening or the final pass not going to hand.

After 20 minutes Elliott missed a penalty from 35 yards. From the drop-out bad tackling gave Esher 50 yards. Elliott promptly regained it all with a fine long touch kick. This heralded the beginning of 15 minutes sustained attack. The forwards won almost constant possession from line-outs, and Hey's hooking ascendancy (four to two heels against the head) became apparent. Although Osborne retired to the wing with a leg injury, and Price came inside, the backs were moving very well. A half break by Price after a dummy scissors was well supported, and brought Guy's to the Esher line. A move to the left was rushed into touch by a worried Esher defence. The forwards then commenced a short-passing movement from the back of the line-out. Unfortunately a good move was spoiled by a knock-on three yards short of the line. Soon after, Moore broke blind from a scrum, but outran any support and was dispossessed. Guy's switched to the opposite wing, where from another line-out Rowlands jinked beautifully through the forwards, passed back inside, and Moore dived over for the try. Elliott converted from touch with a triumphant kick. From the re-start Guy's attacked, and Elliott added a dropped goal from 25 yards. This ended the game, an encouraging victory, and the spirit displayed bodes well for the Cup competition.

Guy's: D. R. Elliott; D. Barford, D. J. Osborne, R. J. Beacham, J. F. Price; B. J. Rowlands, B. W. R. Moore; J. Davies, G. B. Hey, A. J. Kingdon, C. Neville, J. M. Cockburn, C. W. Thorburn, K. G. Brown, H. C. Sharp.

I. M. MORRIS

HOCKEY

GUY'S v. BEXLEYHEATH

Away. December 3rd, 1966

Result: lost 3—0

A weakened Guy's side started the first half playing up hill, and for the first ten minutes were mostly on the attack. However, a long pass by one of the Bexleyheath full-backs started a quick break-away which caught the Guy's defence off guard and they scored their first goal. Shortly after this, mainly through half-hearted tackling by the defence, Bexleyheath broke through again, and their left-inside forward beat Ryland with an unlucky bounce. The ability of Bexleyheath to move onto the attack quickly was evident. Starting with long fast passes down the centre, our defence was caught off guard, and ten minutes before the first half, Bexleyheath scored their third goal.

Guy's started the second half three goals down, and from the start played with more fire and settled down as a team. Some hard tackling by the defence, and accurate passing by J. Crafts, at centre-half, enabled the forwards to move onto the offensive. Appleby and Steer linked up well in the centre, and Godfrey, deputising on the left-wing, played particularly well, hitting the post once with a very hard shot. Guy's played well and with more determination in the second half, and were unlucky not to score at least one goal.

D. B. A. SILK

Guy's: D. Ryland; D. Crafts, M. Vellacot; C. Pearson, J. Crafts, R. Kendrick; A. Brooks, M. Appleby, D. Steer, S. Cripps, T. Godfrey.

GOLF

Hospitals' Cup Final
GUY'S v. BART'S

At the Berkshire Golf Club.

30th November, 1966

Result: won 3½—1½

It was a fine day for golf. The team arrived early for some needed practice and were surprised to find the opposition had arrived earlier. After an ample lunch, the team adjourned to the first tee to see P. Ellis drive off; at once the team's fears were dispelled. The captain won at the 17th hole.

M. J. Brummitt, playing in his third successive golf Cup Final, played some fine golf to beat his opponent 6—4. M. J. Brummitt, always an idiosyncratic dresser on the golf course, was this time attired in a Mersey-side hat.

A. B. Bevan-Jones, playing in his fourth successive Cup Final—an example of his truly magnificent contribution to Hospital Golf—played well to half his match. Much to the joy of his opponent the match was abandoned in the middle of the 19th hole after the other results were known.

The fourth match resulted in the only loss for Guy's. Suffice it to say the match was remarkable for the low standard of the golf; the Bart's captain won 2—1.

A. J. Philips, the Welsh wizard, overcame his opponent. The coup de grace being a felled tree crashing to the ground as his opponent putted on the 16th green.

For the record, Guy's have now won the Cup for the last four years, and 12 times in the last 16 years.

N.C.

Results

P. Ellis (Capt.) v. J. Grieve 2—1.
M. J. Brummitt v. P. Jadler 6—4.
A. B. Bevan-Jones v. G. Hoppe Square
N. Curry v. M. Bowen (Capt.) 1—2
A. J. Philips v. M. Begent 3—2

REVIEW OF 1966

The season has been one of partial success. Two weeks ago the Hospitals' Cup was retained by a margin of 3½ matches to 1½. However, we relinquished both the Beveridge and Eckhoff Cups and yet again lost to the staff at Huntercombe. During the year Bruce Bevan-Jones, Michael Brummitt, David Adams, and Peter Ellis have been regular players for the University, while Alan Philips, Noel Curry, Kirk Weir, and Guy Williams played in the occasional match.

Next season we shall be without the services of Bruce Bevan-Jones and Michael Brummitt. Bevan-Jones captained the University two years ago in a season when they beat both Oxford and Cambridge; for the Hospital he never played in a losing Cup side. Brummitt was both Captain and Secretary of the Hospital and has earned a reputation for his skill and reliability; earlier this autumn, while playing for the University at Addington, he defeated the young Walker Cup prospect, Peter Benka. To replace these two will be hard, though we have two 4— handicap players in David Elliott and David Davies. If Elliott can be coaxed from the rugger-field and Davies from the library, we should have another strong side next year.

PETER ELLIS
Captain, Guy's Hospital Golf Club

BOXING REPORT

GUY'S A.B.C. and LYNN A.C.
v.
OXFORD UNIVERSITY A.B.C.

On Thursday, 1st December, Guy's held their first home fixture of the season when we combined with a team of boxers from the "Lynn Athletic" Club to take on a visiting team from Oxford University. The show proved to be a success, and the bouts were contested before a full house of enthusiastic and highly vocal supporters.

In the first bout, A. Holmes, of the Lynn A.C., boxed against the rangy D. Taylor of Oxford. In the first round, which was full of action, Taylor went storming into his shorter opponent and looked as if he might score a knockout: but as the round progressed Holmes came into his own and dropped his lanky foe with a swishing roundhouse right. The second round was a replica of the first until mid-way through the round, when exhaustion overtook both contestants—both collapsed to the canvass, Taylor from a punch and Holmes from the effort taken to throw it. Holmes regained his feet, and after a few more punches the referee stopped the contest to save Taylor from further punishment.

In the second bout, D. King, of Guy's, won the first round against P. Thick, of Oxford, by using a crisp right lead and some neat evasive footwork. Unfortunately, he could not keep up the good work and after being dropped in the second round, went on to lose on points to a fitter Oxford boy.

D. Davidson, of Guy's, and B. O'Dwyer, of Oxford, had a "rare old punch up" for the first round until Davidson was dropped on his hands and knees from a combination of punches from his Oxford foe. After this a damaged eye suffered by Davidson forced the referee to intervene in what promised to be a good scrap.

S. Marsh, of Guy's, looked good in winning the first round against S. Forrest, of Oxford. Unfortunately Marsh ran out of steam in the second round and as his defence went to pieces, his Oxford opponent picked him off neatly with enough left leads to earn the decision.

The most skilful bout of the evening was between G. Williams, the hard-hitting Lynn stylist, and J. Borgars, the Oxford double blue. Borgars, a tough two-fisted scrapper, found his attack blunted by the neat way his opponent slipped his punches, and Williams speedily countered with rapid two-handed combinations to head and body that had the Oxford boy teetering on rubber legs on occasions. The difference in class began to tell in the second round, and after Williams had staggered Borgars with a vicious left hook the referee intervened to save the Oxford boy from further punishment.

All in all, the evening was a great success, with Oxford deservedly winning the tournament by five bouts to four.

Unfortunately, Oxford were unable to match our two most experienced boxers, R. Stansfield, the heavyweight, and W. Onyeama, the Guy's boxing blue and last year's Captain. If these two had fought then the overall result could have been in Guy's favour.

Classified Results

A. Holmes (Lynn) bt. D. Taylor (Oxford) Stpd. 2.
D. King (Guy's) lost to P. Thick (Oxford) pts. 3.
D. Davidson (Guy's) lost to B. O'Dwyer (Oxford) stpd. 1.
S. Marsh (Guy's) lost to S. Forrest (Oxford) pts. 3.
S. Sheridan (Lynn) lost to T. Faber (Oxford, Capt.) disq. 3.
G. Larter (Lynn) bt. P. Robertson (Oxford) pts. 3.
G. Williams (Lynn) bt. J. Borgars (Oxford) stpd. 2.
T. McSweeney (Lynn) bt. S. Watson (Oxford) pts. 3.
J. Elroy (Lynn) lost to D. Champion (Oxford) stpd. 3.
W. Onyeama (Guy's)
R. Stansfield (Guy's)
not matched.

Other Contests

J. Bullen (Lynn) bt. L. Valar (Belsize) stpd. 1.
M. Fennel (Lynn) bt. K. Bennet (Belsize) pts. 3.

W. ONYEAMA

HOSPITAL INFORMATION

APPOINTMENTS VACANT

GUY'S HOSPITAL, S.E.1.

Applications are invited for the post of **Registrar in Ear, Nose and Throat Surgery,** with duties commencing 1st February, 1967, or as soon as possible thereafter, and appointment until 30th September, 1967, in the first instance. Forms of application are obtainable from the Superintendent, Guy's Hospital and should be returned not later than **15th January, 1967.**

GUY'S-MAUDSLEY NEUROSURGICAL UNIT

Applications are invited for the resident post of **Senior House Officer,** for the six months commencing 1st February, 1967. The Unit, which is housed in the Maudsley Hospital, serves both Guy's Hospital and the Bethlem Royal Hospital and the Maudsley Hospital. Applications should be made by **14th January, 1967,** to L. H. W. Paine, House Governor and Secretary, Maudsley Hospital, Denmark Hill, S.E.5.

PERSONAL

THE BIRDHURST NURSING HOME is now under new management; fees from 12 gns. weekly. Phone Matron, CRO 2277.

CHANGES OF ADDRESS

G. K. Lacey, Esq., L.D.S., The Old Pound Cottage, Little Bookham Street, Little Bookham, Surrey. (Phone: Bookham 2117).

Dr. R. W. Penny, 42, Downsview Road, London, S.E.19

Dr. and Mrs. Patrick Stone, Butts Green Hall, Sandon, Nr. Chelmsford. (Phone: Danbury 3321).

E. A. Williams, Esq., F.R.C.S., 22, Jack Straw's Lane, Oxford. (Phone: Oxford 62647).

BIRTHS

MABERLEY.—On 7th April, 1966, to Barbara and Mike Maberley, 20, Aralia Drive, Mona Heights, Kingston 6, Jamaica, a daughter, Yvonne Louise, sister to Craig and Warren.

MOWBRAY.—On 30th November, 1966, to Carolyn (née Arch) and Howard Mowbray, a daughter, Theresa Caroline.

MARRIAGE

BAKER—BAILEY.—On 22nd December, 1966, quietly, at Allhallows, Copperfield Street, S.E.1, Charles Gaffney Baker to Jean Elizabeth Bailey.

DEATHS

ST. JOHN.—On November 23rd, 1966, in Hammersmith Hospital, Henry Noel St. John, F.R.C.S.Ed., D.L.O.

TISDALL.—On 23rd December, 1966, Mr. J. S. Tisdall, B.D.S., L.D.S., R.C.S. (1951), in motor accident. Our deepest sympathies to his widow and two young children.

We would like to remind our readers that all copy for inclusion in the Gazette must be received eight days before the publication date.

Birth, Marriage, Death and Change of Address notices are without charge to subscribers. For Personal notices the charge is £1 1s. 0d. for 15 words, additional five words 10s. 6d. minimum 15 words. Non-subscribers will pay £1 1s. 0d. for all notices other than Personal

GUY'S HOSPITAL GAZETTE

EDITOR D. S. ROBINS

NURSING CORRESPONDENT E. A. MALPAS

FORTNIGHTLY TWO SHILLINGS VOLUME 81 NUMBER 2048

PASSIM

Cony

We print in this issue our valedictions to the late Sir John Conybeare, who died on January 6th. Cony edited the *Gazette* from November, 1916, to October, 1917, during the last three months being House Physician to Sir William Hale-White, and acting as President of the Residents—a formidable record. Of his many Passims we have chosen to print the final paragraph of his last, as it illustrates his practicality, foresight, devotion to students and complete humanity.

> "Then again there are many Guy's men on active service who may well lose their lives before the end of the war. Some of these, we believe, would be glad to leave bequests to a Guy's War Memorial Scholarship Fund. Parents, also, who have lost their sons might also be willing to contribute to such a fund. Let the Treasurer and Governors of the Hospital give old Guy's men and others an opportunity of showing their gratitude to their colleagues who have fallen by opening a War Memorial Fund which will have as its objective not some monument of bronze or stone, but a far more lasting memorial—the education of the sons of those who have given up their lives for their country."

We would ask our readers to note that at Sir John's specific request there will be no memorial service.

Twice As Long

It has become second nature for anyone, from houseman to superintendent, concerned with the organization of medical services to think of the words "available resources" immediately after thinking up a new design or programme. All are concerned in this local expression of a national problem—which of our ideas can we afford, and at cost to what old establishment? The shortage of available finance has crippled and continues to cripple the application of ideas born out of as yet unstilted imaginations, and yet although sporadically these imaginations are tuned to practical possibilities the occasions are just that—sporadic.

In a recent speech of praise the Radcliffe Infirmary in Oxford was revealed as having the lowest cost of treating in-patients out of all the other teaching hospitals in the country. The average cost per in-patient during 1965/66 was £57 12s. 4d.; that of provincial teaching

hospitals was £81 7s. 5d.; and that of the London teaching hospitals, £110 9s. 6d. The factors highly important in this costing were number of patients treated and length of stay in hospital. Whereas the Radcliffe, with 585 beds, had treated in the period of survey 23,110 patients with average stay in hospital 7.9 days, Guy's with the largest number of beds of the London teaching hospitals—860—treated only 18,824 in-patients with average time in hospital 14.4 days.

Living in London is recognised as an expensive hobby and it appears that a stay in hospital in London is similarly upgraded. Basic costs, i.e. without investigations or treatments, may be difficult to lower, but that the length of stay should be almost twice as long cannot really be put down to patients being twice as ill. Efficiency on a similar scale to that of the Radcliffe is clearly lacking, and it is not unusual to note how a patient may be admitted, e.g. a biopsy, to be found to be generally unfit for the operation, and to be kept in the ward for many days, if not weeks, until his condition improves, rather than being sent home to the care of his G.P. until fit.

The scope for better planning in advance is still large, and if they are not there as they should be, the above figures should be emblazoned upon the minds of those who control the admission and discharge of patients. Our abilities are second to none—let us make better use of them.

Abortion or Abort ?

The changes suggested in the Medical Termination of Pregnancy Bill have affected the thoughts, if not the actions, of many members of the medical profession since its proposal in June of last year. With 1967 comes the strong possibility of its passage through Parliament and consequently the time for more active thought from every member, qualified and unqualified alike; for, whatever the outcome of the bill, its reactivation and publicity will bring to the surface a deluge of personal and public enquiries.

So far its Parliamentary instigators have included only two doctors, a small representation when dealing with a problem involving the medical profession just as much as the public. This last is made clear when it is remembered that the doctor will be given the freedom to make the best choice for the mother as well as the prerogative to safeguard the health and happiness of her family, always assuming that the bill worms its way through our inevitable democratic sieve without too great a change in identity.

But as the situation stands, with apparently every prospect of results by the early summer, the medical profession is split down the middle. Certainly supporters of the bill include several individual medical authorities, but amendments, if not opposition, have come from all quarters, including the B.M.A. According to one represen-

tative of the national press, however, public support is estimated at 80 per cent. This is a sure indication of popular demand and social necessity and, if this figure is correct, proof beyond doubt that a concerted effort is required by the medical profession to show its true colours.

Most would agree that changes must be made. The present law is unsatisfactory, recognising the need for abortion in certain extenuating circumstances but offering such inflexible parameters that it not only presents no deterrent but has probably led to the increase in incidence of its illegal practice. Such practice directly contradicts the principle of the Welfare State in so far as it costs much and causes unnecessary suffering and death.

Surely it is the duty of our noble profession to endeavour to rectify this situation by giving the bill full support? Demand for certain alterations is expected but anything which unnecessarily hinders the rapid institution and fulfilment of this bill can do nothing but prolong the effects of this outmoded facet of our law. This is not to say that the individual will not be able to act by his conscience, freedom of this entity is respected to the full, but for those who will exercise with clear conscience and compassion this new-found privilege, the wait has been frustrating and often heart-breaking. It has caused nothing but a struggle with their own common sense, almost to the point of temptation.

Students, as well as doctors, can help put an end to this struggle by giving this bill the support it needs. But while members of this fraternity continue to remain men of conscience, a total affirmative response is unlikely. It is obvious, therefore, that should opinions remain diametrically opposed, as is the present situation, the public must be given the benefit of the doubt.

The present law is old and confused. It is also only inhuman in its effects.

R.E.C.

We offer our congratulations, with apologies for the belatedness, to the following Guy's men who received awards in the New Year Honours List:—

O.B.E. (Military):

Surgeon Commander Peter Warren Head, M.B. Lond., R.N.

O.B.E. (Civil):

Eric Ralph Davies, M.B. Lond., F.R.C.S.

It is with sadness that we record that Gordon Willie Garland, M.D. Lond., F.R.C.O.G., Obstetric Physician to St. Thomas's Hospital (Guy's 1938-1943) died on January 4th, after having received the O.B.E. (Civil) in the New Year Honours List.

We congratulate Mr. John V. Jeffs on his recent appointment as Consultant Plastic Surgeon to Charing Cross Hospital, the Westminster Teaching Group (Queen Mary's, Roehampton) and the S.W. Metropolitan Regional Hospital Board.

We would draw our readers' attention to the fact that in future, Casualty Officer posts will be S.H.O.

HENRY St. H. VERTUE

Vertue's retirement at the age of 65 did not at all please him, devoted as he was to clinical medicine, but he fortunately found a congenial outlet as a medical referee to the Ministry of Health.

At Oxford he had been lucky enough to fall under the spell of Osler, with whom, because of his great love of the humanities, he was a kindred spirit. He told me he chose Guy's because of his admiration for Hurst. He will be best remembered by Guy's men for his work at the Salomon Centre, where he was quite likely to intersperse his teaching with a quotation from Keats or Shelley.

Although I remembered him as a registrar in the early 1920's, I did not begin to really know him until many years later, when I came upon him in a tube train reading his beloved Lucretius in Latin. He was a classical scholar who wore his learning lightly, but could not conceal his distaste for hybrid neologisms, or the accepted mispronunciation of *poliomyelitis* and *geriatrics,* or what he termed *the jargon of the psychiatrists.* He loved books and possessed a fine scholar's working library. He also loved writing and frequently enriched the pages of *The Gazette* with beautifully written papers whose merits, I suspect, frequently escaped notice except by the *cognoscenti;* while his contributions to the *Guy's Hospital Reports* were outstanding, particularly *An Enquiry into Venereal Disease in Greece and Rome* and *Henry Lamb at Guy's,* which, since he was a friend of Lamb, was written *con amore.*

He had a keen sense of humour and a hearty laugh which could reverberate across the Park from the Medical School to the Colonnade. He appreciated the good things of life and liked his friends to share his enjoyment.

He was a lovable and gentle person whom I never heard criticise a colleague, nor, indeed, anyone else. He was truly a learned physician of whom it might be said, as Dr. Johnson said of the elder Heberden, that he was *ultimus Romanorum.* By his death, Guy's has lost one of its most devoted sons who will be greatly missed by his many friends among the older generation of Guy's men.

G.O.M.

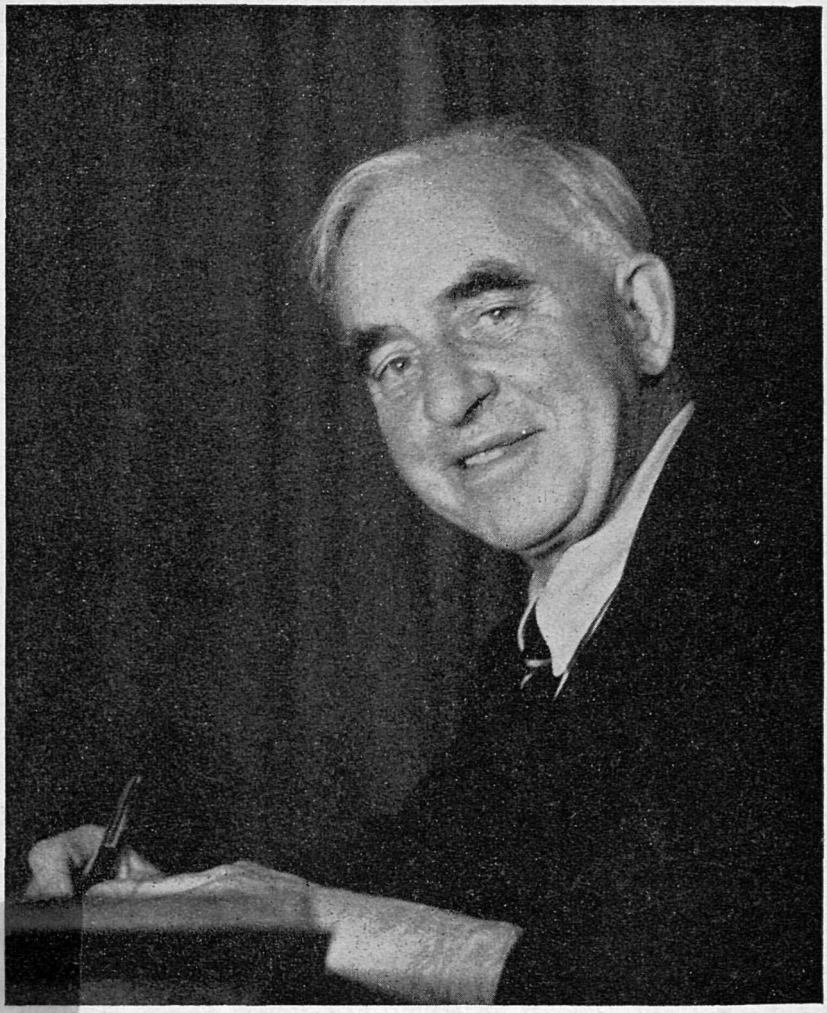
GUY'S DIARY

JANUARY

23rd	M.	1.00	Clinical Lecture, Dr. MARY SHERIDAN. "The Development of Communication in Young Children." Note: This is in place of the lecture cancelled owing to power failure.
24th	Tu.	1.00	Clinical Lecture. Prof. BUTTERFIELD.
26th	Th.	1.00	Clinical Lecture. Mr. HUDSON. "Intravenous Flourescein in Ophthalmic Diagnosis and Treatment."
		4.30	Physiological Society. Mr. H. WILLIAMS. "Pitch."
27th	F.	1.00	Clinical Lecture. Dr. KAUNTZE. "Cardiac Failure."
28th	Sat.	10.00	Clinico-Pathological Meeting: In the Clinical Theatre.
30th	M.	1.00	Clinical Lecture. Dr. STAFFORD-CLARK. "Bond in Biochemistry: Drugs as Double Agents."
31st	Tu.	1.00	Clinical Lecture. Mr. ECKHOFF. "Fracture of the Facial Skeleton."

FEBRUARY

2nd	Th.	4.30	Physiological Society. Mr. C. WILDE. "The Nucleo-Protoplasmic Relationship."
3rd	F.	1.00	Clinical Lecture. Dr. HOUSTON.



SIR JOHN CONYBEARE,

K.B.E., M.C., D.M., F.R.C.P.

John Josias Conybeare, Physician Emeritus to Guy's Hospital, died suddenly in his home in St. Thomas's Street, on January 6th, 1967, at the age of 78.

Apart from term-time at Rugby, he lived his early life in the academic atmosphere of Oxford, and his early manhood was spent at New College, where his classical education preceded his interest in medicine. The First World War took him to France as an infantry officer and he gained the M.C. Later when he had been seconded

from the Army so that he might quickly qualify as a doctor, he served in the R.A.M.C. in Mesopotamia. When he was demobilised he came back to Guy's as Medical Registrar; he became Warden of the College in 1923; he was appointed to the staff as Assistant Physician in 1925, and became Sub-Dean of the Medical School. By 1929 he had published his Textbook of Medicine which immediately became a standard work, and which continually occupied him in the preparation of thirteen subsequent editions. The nineteen-thirties were filled for him with his busy life at Guy's and with the friendships he forged in the Hospital. The year 1939 found him once again in the midst of another war, and from the start he gave all his energies to service as Consultant to the R.A.F. He served throughout the Second World War as Air Vice-Marshal, and his great contributions were recognised when he was created K.B.E. in 1945. He came back to Guy's and again became completely identified with the activities of the Hospital, and was elected a Governor in 1946. For the next eight years he devoted every day, and half of every night, to his clinical and teaching duties and to the sociable spice he brought to every activity in the Hospital and School. When he retired from the active staff in 1953 he lost none of his accustomed interest and influence. He lived with us and for us. He died, as he would have wished, in the midst of his friends and in the surroundings he loved so well.

A brief summary of some of the outstanding achievements of his life is but a poor tribute to a man who was unique in his generation of Guy's men. He was "Cony" to everyone. His name always set off a trail of happy memories of enterprises and escapades, reputable or otherwise, but always colourful and always designed to help the oppressed and to humble the arrogant, and always (in Cony's opinion, at least) to the greater glory of Guy's. He was remarkable for his outstanding personality and for his enjoyment of the company of his fellow men. He could rebel against authority, yet exercise his own. He expected his own standards from those who worked with him, yet he would never let oppression pass unchallenged. He felt strongly, and when he championed a cause, the less important the people concerned, the harder he fought for them. He found his pleasure, and indeed in his later years his whole purpose, in his association with people; among these it was the young men who knew best the generosity that went with his friendship. The extent of this generosity will never be fully known, because Cony took great pains to conceal it; but the individuals themselves—and they are many—know full well what they owe to him.

Cony lived at Guy's—apart from the interruptions of two wars—for half a century. The College was his first home and when he had been Warden for fourteen years it was rumoured that he was leaving. But anxiety at Guy's was soon relieved when it was realised that he was moving about 100 yards as the crow flies to 14, St. Thomas's Street. With a twinkle in his eye he confided that he had negotiated a long lease so that he could be sure of staying there for the rest of his life. And so he did, to the benefit of his beloved Hospital, to the continued joy of all his friends, and to the fulfilment of the simplicity and unselfishness of his own ambitions.

The death of a hero—for that, after all, was what Cony was—is always the occasion, not simply for the tributes and lamentations of all who loved and admired him, but inevitably marks the end of an epoch, and therefore the beginning of another. The burdens which he laid down have to be lifted and carried onwards by the rest of us, until it is our turn to hand them over. So many of Cony's innumerable friends and colleagues will have wished to acknowledge, and many have already succeeded in acknowledging, his greatness as a physician, a teacher, a friend, and an example of what those things should mean, that we must spare ourselves the indulgence of overlapping; which he would have been the first to detect, and kindly, but as always decisively, to deplore. So may I be permitted to record simply and on behalf of so many of us, that we loved him: and perhaps that what we loved most of all about him was his own love of justice, courage, and principle; but we loved too his laughter and the memory of innumerable shared revels and the occasional sharp but never undeserved rebuke. We were lucky to be alive at the same time with him, for however long or short a period; and the ways in which his own love of Guy's, and of all that was or could ever be best in the traditions of this diverse and remarkable family, will be one more deathless and invaluable memory as long as the name of Guy's is remembered anywhere at all.

D.S.-C.

It will have been a sad shock to countless Guy's men to realise that the familiar elderly figure in the well-worn suit and aertex shirt is no longer among us. Cony had become almost an institution of the Hospital, continuing to show in his retirement an unfailing interest in all connected with it. Many would receive the famous invitation " You must come to dinner", and enjoy the unique warmth and hospitality always characteristic of No. 14, St. Thomas' Street. Rarely did one fail to be invited again, and for many in later years it would become a second home while visiting London.

A special sense of loss will be shared by those who, as students, were privileged to be residents in the flat, a line stretching back thirty years to the time when Cony was Warden of the College, his earlier home. They will have extra reason to recall his larger-than-life personality, his good humour, and remarkable capacity for taking a thoughtful interest in other people's problems. One would be startled by the same topic suddenly turning up in conversation days or even weeks later, fully considered, and often with invaluable suggestions or advice discreetly added. His concern for those in need at a difficult time was endless, and his generosity was quite extraordinary. He confessed once that a reason why he had owned so many cars (well over thirty) was that he liked to run two at a time, in order to have one to lend to others. Many a holiday has been made possible by this remarkable tradition.

Memorable also was his hostility to any form of pretentiousness or snobbery. Cony's sympathies were always with the man in the street, and he tended towards radical views, in spite of the distinctly aristocratic standards observed in everyday life in the flat. There were also the eccentricities: Commercial television was banned, and on arrival of a new set, the dumbfounded electrician was requested to disconnect the offending channel at once. No amount of persuasion would ever alter his insistence on coming "down" rather than "along" for breakfast in his single floor flat. All who knew him will have their own treasured recollections, which leave a special void this time.

Outside medicine, Cony had a wide range of interests, which became increasingly important to him in his retirement. Amongst these he was a keen antiquarian, and in later years, although limited in speed, he would leave others exhausted at the end of a day's sight-seeing. His lively interest in church architecture has fired the enthusiasm of many, with lasting effect.

It will be comforting to his friends to know that although recently short spells in Nuffield House had become more frequent, he was at home in his flat at the end, and had been busy writing the customary pile of letters to the many that had been in touch with him at Christmas.

N.E.J.

CONY STORIES

One of the first questions—and often the first question—an old Guy's man has almost invariably asked about his hospital is: "And how's Cony?" When old Guy's men met privately or publicly, stories of Cony were told. It is for this reason that it seems appropriate to add to the memorial of him in the hospital journal some stories which to the writer seem to illustrate the many facets, already mentioned in the many official obituaries, of this loveable man. In reading them, his well-known Tudor adjectives and expletives can be added to taste, and in the mind's ear should be that very characteristic drawling timbre of voice, so often imitated with varying success at Guy's gatherings or Residents' Plays.

The first story is about the voice. I once casually turned on the radio and was greeted by this unmistakable sound—it was a symposium on Lord Nuffield—and when reporting this to Cony, he said: "A lot of people said they recognised my voice. I suppose it must be peculiar. I expect it's my Oxford accent". His memory of old Guy's men and their doings was astonishing, but of course this was because no other senior Guy's man had so genuine and so personal an interest in his students. On returning from one of his visits to South Africa with George and Margaret Doherty—which were like a royal tour in the gathering and binding together of the large Guy's community there—he confessed with evident shame: "I met a young man who qualified a few years ago. I couldn't remember him, but he remembered me". This illustrates his modesty, for Cony was completely lacking in the pomposity which so often and almost inevitably is a feature of the distinguished medical man. This must have contributed to his success as Consultant in Medicine to the R.A.F., for he was sympathetic and approachable to those with either personal or medical problems, provided they were genuine, for he was litmus to the bogus or shirking. It is characteristic that he was wounded in his second World War with fractured ribs sustained in post-prandial mess exercises. He had a capacity of deflating the pompous or boring as once when a lady had for too long and too often entertained a holiday party with stories of the hunt and of her husband, the M.O.H. These repeated sagas of the chase were stopped and never repeated after Cony had innocently asked: "Why do the dogs run after the fox and want to kill him? They're the same kind of animals, and I would expect them to fraternise. I suppose you have to train them."

His dislike for organised religion was contradicted by the friendliness and kindness to successive Chaplains to the Hospital and his practical interest in their welfare. "I was never confirmed, or baptised either for that matter" often prefaced or explained anti-religious views such as the dictum: "When I find a young man who

is intensely religious, I know that something is not only wrong, but radically wrong". When the writer was his house physician, he told me of a shattering experience that he had just suffered as Acting-Superintendent. "I was showing some Governors and visitors round the hospital, and I took them into the Chapel. It was terrible, there were some students in there, and what do you think they were doing?" "I hope they weren't doing anything with the nurses", I replied. "Oh no, it was much worse. It was most embarrassing. I can't think what the Governors thought. They were—praying!"

Some years back Cony managed to arrange that the hour-chiming of Southwark Cathedral should be stopped throughout the night as they were disturbing the sleep of the neighbouring householders, including himself, but particularly the patients in Guy's, and he himself paid for the necessary alterations. This benefaction was reported in the Diocesan magazine, or similar journal. His distress at this publicity—"They'll think I'm some interfering God-botherer"—was only partially allayed when it was pointed out that the majority of his friends and admirers did not subscribe to the magazine. A senior friend and physician reported a discussion with him about the arrangements they would individually wish for on demise. Cony said that he wanted no ceremony of any kind, but that he merely wished to be cremated at ——— Crematorium. Asked why he bothered to specify this particular institution, he replied: "Why? Well, you see, I've got shares in it". This typical and practical streak—he was a very shrewd man of business—was also demonstrated when he had recurrent trouble with a new washing-machine in his St. Thomas's Street flat. The maker's repeated failure to give satisfaction under the guarantee was quickly altered when he wrote to them of his intention to put an advertisement in the Personal column of the *Times*: "—— washing machine recently purchased, as new, with guarantee, five pounds to first applicant".

He was a pioneer motorist with many good stories, which included a journey from Oxford to London as an undergraduate, when a leaking radiator was repeatedly replenished by water from streams and horse-troughs conveyed in his bowler hat. It was very amusing to observe the astonishment of the owners of the oldest cars at a Vintage Car Rally at his practical knowledge of the mechanism, and snags, of their individual models. Perhaps the leisured speed of those days was largely responsible for his dislike of being driven fast and the constant interjections from the back seat to his excellent pre-war chauffeur, "Not so fast, Rance." Once, on an Austrian mountain road where the not unusual interest of the driver for a combination of local gossip, adjacent female charm, and the feel of his accelerator appeared to be leaving little room between the outside wheels and the valley below, he nervously enquired of his companions what the word for "slow" was in the language. They cruelly and perversely supplied a word and similarly enjoyed his mounting consternation as repeated shouts in louder and higher tones of "Schnell, schnell, for —'s sake schnell," failed to produce the desired effect.

Another story, which he enjoyed hearing, of embarrassment caused by his friends was the constant attention of a lady with a marriageable daughter on a holiday, which stemmed from a casual remark by a celebrated anaesthetist friend of his, "Dr. C. is a bachelor and has been left a small fortune if he marries within the next year. But I don't think he will, for he's quite rich without it." And there was the occasion when the Girl with the Golden Voice first answered when you dialled TIM. Cony was told of this obliging lady at the Exchange and was persuaded to ring her. His usual courtesy to women was shown by his replies, "Thank you very much. It's very kind of you. I didn't need it quite so accurately. (Oh dear, she's going on.) Thank you very much, I heard you very well the first time, I must ring off now." And, of women, his reply when asked if he was going to attend a Residents' Ball: "As a matter of fact, No, I can't stand women in bulk."

A story to illustrate his personal involvement in world events to which he reacted with vigour and emotion. At the time of the Hoare-Laval pact when sanctions against Italy had been imposed in protest of their aggression in Abyssinia, his man-servant in the Warden's House entered with the customary tray of evening drinks. A bottle of Italian Vermouth was seen on the tray and there was an angry and agonised shout, "Whiting, I told you there was to be no more of that drink in this house." As the offending bottle was borne away in a very agitated and shaky hand, Cony remarked with coy and apologetic satisfaction, "That should scupper the b——s." Whiting did not reappear after the war, when Cony returned with a fixed resolve that life must change to a more austere and unindulgent pattern. He refused to attend social functions which necessitated evening dress which he frequently pronounced as redundant and socially offensive. But there was always a practical and personal side to his idealistic views, which came to light some time later when he had once again consented to put on a black tie and conform: "It's a fearful fag; it was all right when one used to have a man to put the clothes out and fiddle with those studs and things."

His delight in travel and his appreciation of art was enlivened by his enquiring mind and passion for detail. This is illustrated by an occasion when the writer called at St. Thomas's Street with a lady-doctor friend who was staying in the Warden's House. There was the usual collection of friends, old and young, and the usual animated conversation, but my friend was astonished at Cony's opening remark after he had warmly greeted her and supplied her with a drink, "Did you know that 68 per cent of virgins nursed their child on the left breast?" to which she immediately replied, "I'm very sorry, but it doesn't make sense to me." It was then explained that on the last Continental holiday he had organized with his younger guests a count of all pictures and statues of the Virgin encountered, thus confirming an artistic hunch into a fact, for which he had anatomical and physiological explanations.

Of his own illness two stories. He gave a clinical lecture on Coronary Artery Disease, illustrated by his own experience, including the emotional factor in producing angina. He had opposed the establishment of a branch of Smith's in the Park, and told his audience, "I have to suck a T.N.T. every time I pass that confounded book-shop." The second occurred at a time before external cardiac massage was introduced and when there were repeated incidents when collapsed patients were having their chest opened for internal massage in out-patients, lifts, and in the wards. As a champion of the under-dog and the unjustly criticized, he indignantly told me how one of his young men had been reproved for making an unsuccessful and messy attempt. When I pointed out that many elderly patients with coronary disease might feel it inappropriate, unnecessary and interfering to be dealt with in this way he immediately, as expected, saw the problem from his own viewpoint. With "they'd better not do that to me," he continued on his way to his flat, where no doubt immediate and emphatic instructions were given to his young residents.

These young men deserve all our praise and thanks for the support and devoted care they gave him in his last years, as do the nursing staff of Nuffield House, where he always enjoyed his short periods of enforced rest, and particularly two sisters who will be readily identified but would, I feel sure, prefer to be nameless. To one who observed his steady deterioration in health over the last year, his sudden death was merciful, particularly as he was increasingly distressed by his failure to remember Guy's people and events though his interest and care for them was as strong as ever.

C.G.B.

The Building Programme for General Practitioners

1967 - 1980

by Alfred Lester, A.R.I.B.A.

There is a need to examine the type of buildings that will be used by general practitioners in the foreseeable future. No plans for urban renewal, for new towns or for new hospitals can be complete without some knowledge of their needs. No impetus can be given to the recruitment of G.Ps. unless there is some prospect of improvement on the present methods of practice.

The pattern is fairly clear up to 1975. The period beyond is a matter for conjecture which the writer has based on his recent visit to U.S.A. It is reasonable to suppose that the material progress now in evidence there, will reach this country before 1980.

1967—1970: Consolidation of Group Practice

The latest injection into general practice of additional financial incentives to encourage the development of group practice premises is reinforcing an existing trend. Group practice emerged as a means of providing a 24-hour coverage of patients whilst allowing a certain amount of free time to the G.Ps. It allowed also a sharing of staff and premises with a consequent reduction in expenses. It permitted the introduction of appointment systems to lessen the waiting time of patients and to regularise a haphazard load pattern on the G.P.

There was a tendency at first to retain the original surgeries from which the groups enlarged as branch practices. But as competition for patients lessened between G.Ps., branches were closed down and centralisation of records and ancillary help became possible. This proved to be a more efficient way to practise and groups became large enough to warrant the attachment of part-time and sometimes full-time local authority staff.

It was realised that the grouping of G.Ps. countered a tendency towards the isolation of single-handed practitioners from their colleagues. The grouping was welcomed at Ministry level and financial assistance was given in the form of long-term interest-free loans which promoted the establishment of many new premises and large scale conversions of existing buildings.

It became obvious in the early 1960's that little was known about the way in which G.Ps. could practise together in groups and the sort of premises that could foster the best conditions for general medical practice. This lack of basic knowledge was recognised. A series of studies was set up by the Practice Organisation Committee of the College of G.Ps. and a full-time General Practice Advisory Service was established to supersede a part-time honorary service.

The studies show a wealth of individual ideas on organisation many of which emerged from the exploitation of chance circumstances. For example, the principle of shared consulting rooms would be applied in circumstances where there were more G.Ps. in a group than consulting rooms. The appointment system would come soonest when conditions in a waiting room became chaotic. G.Ps., when asked for their opinion on the maximum number of doctors who could practise together in a group, would usually answer in terms of one more than the current size of their group.

In a subtle way the almost accidental plan of the doctors' premises is the most important factor which determines the present accepted pattern of group practice premises.

The studies culminate in a "Design Guide" prepared by the National Building Agency and the College of G.Ps., which is to be published early in 1967 and which covers the typical situations and planning aspects that doctors and their architects need to know before embarking on a design for a new surgery. It incorporates all the different types of activities that are commonly found in general practice today. It settles once and for all the question of mass-production of group practice centres by showing that the national programme is too small to warrant a special development of its own. It lists, however, the types of prefabricated buildings that would be suitable for group practice premises.

1970—1975: The Health Centre G.P.

This period is classified as the age of the Health Centre not because there are none at present but because the present Health Centres, built under Section 21 of the N.H.S. Act, have very little in common with the stated aim of linking the two arms of the Health Service. Up till now there has been little to encourage the G.P. to practise in a Health Centre. The local authority orbit and the G.P. orbit have remained independent for the most part and the demand for economic rent has restricted the amount that could be expended on the G.P. section. The G.P., for his part, has been reluctant to participate because he could see no advantage in over practising from his own premises.

Virtually overnight with the coming of the doctor's charter there was a revival of interest in the Health Centre. Local Authorities felt they had to take quick action in order to maintain the G.P. service to the voters—if they left the matter to resolve itself they might find the drain of G.Ps. both abroad and to the more desirable areas denuding them altogether. The vicious spiral created when G.Ps. leave an area to unburden their patients onto already overburdened G.Ps. is a state of affairs that demands action. Some local authorities suddenly found they had to start attaching their staff to G.P. practices even if it did interfere with their own traditions. Some, like the West Riding had a cool look at their own underused clinics and set about making these available to G.Ps. The majority of local authorities

started on a plan for building Section 21 Health Centres which are likely to come to fruition in the 1970-75 period. This, in the name of Community Care, is to urge the G.P. to stay.

What form are these Health Centres to take? No one knows. Each authority is developing independently. The successful Health Centres of the past are few. Among these are the Harlow centres, which are Nuffield projects outside Section 21.

A few teaching hospitals are planning experimental Health Centres. In Scotland there is an example of a Health Centre built in hospital grounds. Oxfordshire has another example and, of course, there is the Guy's Hospital project in the Woolwich and Erith new town.

The results of these attempts to integrate the G.P. into all three arms of the health service may well come to fruition in this period and are likely to be the most important pointers to the future of general practice. It is at these centres that most of the teaching will be done and a new breed of G.Ps. can be created if desired.

Local Authority provision of an equipped building means that the G.P. no longer has to find a site and build and maintain premises in the open market of rising costs. More and more G.Ps. are finding this an attractive advantage, particularly as the charges for rent and services are recoverable.

The stabilised groups are most easily absorbed into Health Centres as there are considerable planning and administrative difficulties involved in absorbing individual practitioners. The latter, however, is likely to be the most common inhabitant and it can be expected that the development of privately owned group practices will continue alongside the development of health centres.

1975—1980: Preventive Medicine

In the period a decade from now we can assume that more will be known in the field of screening and preventive medicine. Automated tests are likely to be more numerous, more efficient and reliable and it is probable that the diagnostic centre of this era will be somewhat on the lines of the Kaiser Permanent Multiphasic Screening Unit in Oakland, California. (As a layman I understand that the case for this type of multiphasic annual check-up has not been established but I am considering it in terms of the gradual increase of automated diagnosis and statistical information that is obtainable in this form of centre.) This will also be the era of cost benefit analysis applied to medicine and, if we are to judge by American standards, the age of mass car ownership and mass communication all combined with a population explosion.

The increase in mobility will enable G.Ps. to practise in larger and larger groups as the siting of the premises becomes related to time of mechanical travel instead of the present limitation of distance imposed by the pram pushing mother.

The population explosion means providing a new town the size of Bristol every year from now on. It means more G.Ps. are necessary in what Dr. Fry calls "front line medicine". If these are not available some other way must be found of meeting the demand of the patient, perhaps mechanically, more likely by assistants.

Local Health Authorities are finding their rôle in society in the field of statistical epidemiology research and preventive medicine. This will leave the practice of "front line medicine" fairly and squarely to the G.P. (by whatever name he will be called at this time).

Hospital and G.P. premises can be sited together once the mobility of the population is factual. Such a medical centre would cover a population of 250,000 and would house about 100 G.Ps., which is approximately the size of the Palo Alto clinic in California. It is perhaps questionable whether these large centres would be served by satellite out-stations on the lines of the Woolwich experiment. Feeling in some parts of America seems to be that most doctors prefer to be at a main centre and it would be difficult to staff auxiliary sub-centres.

With the siting of the General Practitioner in hospital grounds must come the removal of the last of the barriers artificially created by the 1948 Health Act—some thirty years after its implementation.

It is to be hoped that the G.P., local authority and hospital can together make a concerted attack on disease and medico-social problems each fully realising the service that can be provided to the patient by the other two arms. Buildings can be planned to integrate the three services, to allow interchange of ideas between the staff of the various departments, to make the practice of medicine a creative activity and provide a living framework of community care.

GUY'S HOSPITAL THEATRE CLUB

A MAN FOR ALL SEASONS

by Robert Bolt

— *A CRITICISM*

Sir Thomas More

It is a thesis that most people are fundamentally unpleasant but that they have redeeming features and the Guy's Theatre Club production of Robert Bolt's play, "A Man for all Seasons", did nothing to disprove it. Its characters were a familiar lot, if not a representative collection of our friends and acquaintances.

We all know the awful Rich—shifty and deceitful, looking around to see how everyone else has voted before he puts up his hand; not so much climbing the ladder of success as being shoved up it. Compared with him the villain Cromwell was almost tolerable; the opportunist lawman seeking out lawbreakers, rightly unconcerned with the justice of the law, but pursuing a course which he rightly suspected would lead to his demise and doing it because it was his duty. He was labelled a pragmatist but this label seemed much more apt for Norfolk who opted firmly for the establishment when the going got tough. Norfolk's saving grace of course was that, at an earlier stage, he would have given up all for the sake of old friendship.

Even before the syphilis had got him, Henry the King was a keen exponent of the Divine Right, which was rather tiresome for his subjects, particularly Wolsey, whose success led him to have ideas above his station. This Henry had an almost childlike need for the approval of the paragon and a tendency to smash up his toys when crossed, but despite this it would be hard to deny that he was effectual. This is quite an accomplishment even for a King and he was redeemed to some extent by his strong poetical-romantic streak, which is more than can be said for the collective Common Man. Perceptive, worldly, cynical, servant and informer, jailer, jury and executioner, all with equal indifference, he alone survived untouched by the chaos of the individual man's lives.

And now for More. What can one do but thank Heaven that such men are rare? The man who would make absolute morality practical where there is only the balance of good to be attained, blinded by his own vanity and selfishness, true to himself and no one

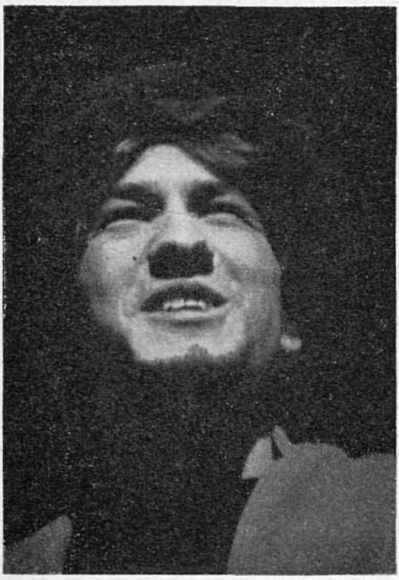
else. He was a bore and dangerous to boot, a rock in the sea that makes the otherwise undisturbed waves dash into breakers.

It must be some measure of the merit of the Theatre Club production of the play that these necessarily brief reflections are wholly the result of their efforts. It is quite probable that they are a gross misinterpretation but even so they are evidence that the characters were distinctly drawn and carried through consistently and with conviction.

The first step to success was made by choosing a sound play, the ideas may not be wildly original but they are always interesting and there is a good story. There was an excellent set, which both looked and worked well, and effective lighting. The producer had evidently approached his task with discipline, sense, and responsibility —no gimmicks or solecisms. This good basis resulted in better acting throughout, the lines spoken with confidence, meaning, and often feeling.

How pleasing it is to see an amateur production that is craftsmanlike. Writing, producing and acting plays is a craft and without craft there can be no art. It is also true that an enjoyable performance such as this can only be achieved by hard work and one can be sure that all concerned have reaped the abundant satisfaction of a job properly done. They are to be congratulated and we can hope that there is more of the same to come.

R.N.



The Common Man

Thomas Cromwell

Richard Rich

CAST :

The Common Man :	John Froude
Sir Thomas More :	Andrew Seal
Thomas Cromwell :	David Graham
Alice More :	Jean Morpurgo
Margaret More :	Wendy Inward
Richard Rich :	Russell Cowan
Duke of Norfolk :	Chris Rowland
Will Roper :	Bob Mackay
Spanish Ambassador :	Nick Flower
Cardinal Wolsey :	Andy Blinkhorn
Archbishop Cranmer :	Richard Wright
Henry VIII :	John Stephens
A Woman :	Sarah Lange
Attendant to Spanish Ambassador :	Andy Blinkhorn

Produced by Peter Davenport.
Designed by Neil Watson.
Stage Management by Max Pearce.

NOTICES

Annual Clinical Dental Meeting

The Annual Dental Clinical Meeting will be held in the Dental Department on Saturday, 4th March, 1967, and the Dental Society Dinner will be held in the evening. A resumé of the programme will be published in the *Gazette* on the 18th February, 1967.

F. S. WARNER.

Dental Society Annual Dinner

The Annual Dinner will be held on Saturday, 4th March, at 7 for 7.30 p.m. at the Park Lane Hotel, Piccadilly, W.1. Mr. R. O'Neil, President of the Society, will be in the chair. Tickets are £2 7s. 6d. each (exclusive of wines), and any guest within the profession will be welcomed.

Application forms are at present being circulated to all those whose addresses we know, but tickets may also be obtained by writing direct to the Dinner Secretary, Dental School, enclosing a crossed cheque payable to Guy's Hospital Dental Society.

S. B. REAR, *Dinner Secretary.*

British Postgraduate Medical Federation

The British Postgraduate Medical Federation will hold a week-end course in paediatrics for general practitioners and local authority medical officers entitled " Clinical and Developmental Paediatrics." This will take place at the Evelina Hospital on Saturday, March 4th, and Sunday morning, March 5th. Applications for a place on the course should be made to the Hospital Secretary, Evelina Children's Hospital of Guy's Hospital, Southwark Bridge Road, S.E.1, as soon as possible.

Miss MacManus

Miss MacManus thanks her many Guy's friends for their remembrance of her at Christmas. She wishes them every happiness and blessing in 1967.

Inflam No. 4

We regret that, owing to the closure of the bar, Inflam No. 4 has had to be postponed till the end of February.

New sound equipment is being installed in the Bar for future Inflams, and this, together with the greater variety of music we shall have by then, should make this the best Inflam yet.

Unfortunately, because of the great popularity of the Inflams, we shall have to ask for Guy's identification in future.

Guy's Hospital Christian Union Carol Service

The collections taken at the recent Carol Service amounted to £19. This has been forwarded to the " Save the Children Fund." We would thank all who gave so generously on this occasion.

CORRESPONDENCE

The Retirement of Sister H. D. Chrimes

SIR,—May I remind *Gazette* readers that the collection which will be handed to Miss Chrimes early in February, will close on 31st January next? If this letter should come to the knowledge of new *Gazette* readers, may I explain that during the last three months, we have been collecting donations for this gesture, and those who would like to contribute may also sign their name in a suitable leather-bound book which awaits their attention in the Matron's Office. The book is divided into three sections:—

Nursing Staff, Past and Present.
Medical Staff, Past and Present.
All other friends.

Those who are abroad and unable to call in to Guy's for this purpose, may certainly forward their signatures on suitable pieces of paper which will then be affixed into the book accordingly. Receipts will, of course, be dispatched without delay. Cheques should be made payable to " Guy's Hospital."

Yours, etc.,

M. A. DAY.

Matron's Office,
Guy's Hospital, London, S.E.1.

War Memorial Arch

SIR,—Since the news in the *Gazette* in September last that the principle of the Tower Block scheme has been accepted by the Minister of Health, detailed planning has continued apace. Before the construction of this or any other buildings on the site can commence, there is a great deal to be done in diverting main services such as sewers and electricity and gas mains and in carrying out necessary demolition. So as to be ready to start on the Tower Block itself when formal approval to the scheme is given, the Governors have decided to carry out preparatory works at Endowment Fund cost in the same way as they have met the cost of planning to date. Contractors will be on site early in February, and it is hoped that details of the sequence of work and its effect on the Hospital's routine may be given in a later issue of the *Gazette*, as well as being given publicity in other ways within the Hospital and School. Because these works will involve an area around the War Memorial Arch, it is necessary to dismantle the Arch, and this will take place in the very near future. The work will be carried out by a specialist firm of stonemasons in such a way that the Arch may be re-erected at a later date and continue as a permanent memorial to those Guy's men who fell in the two World Wars.

Because the archway itself is now really too narrow for present-day roads, even within the Hospital grounds, and following the extension of the Hospital's site up to Weston Street and the closure of Great Maze Pond, the Governors are considering a number of possible alternative sites in the grounds for its re-erection.

Yours, etc.,
A. H. BURFOOT,
Clerk to the Governors.

SIR,—The Residents' Play will be held this year from 20th to 24th February (inclusive) in the Physiology Theatre. Applications for tickets are invited, and should be received before February 10th, when the final allocation of seats will be made.

Yours, etc.,
SIMON M. WOOD,
President of Residents.

Dental Auxiliaries

SIR,—The answer to the question posed to me by your correspondent is "yes."

Yours, etc.,
J. N. PEACOCK,
Secretary, British Dental Association.

64, Wimpole Street,
London, W.1.

[*See correspondence* 7.1.67.—ED.]

Dr. Vertue

SIR,—In the tributes to Dr. Vertue there has been no reference to his interest in John Keats. The books published in recent years by Aileen Ward, Professors Bate and Hyder Rollins, of Harvard University, have shown how 146 years after his death, Keats' writings are highly valued and are of international repute.

Dr. Vertue had a keen interest in mythology, which was akin to that of Keats and gave a real interest to the papers which he contributed to this subject.

Yours, etc.,
F. N. DOUBLEDAY.

Guy's Hospital,
London, S.E.1.

Henry St. Hill Vertue

SIR,—In earlier years that benign smile and Jovian laugh were to be seen and heard in this Department on many occasions, and I offer my tribute to his memory in a form in which, I think, he would have delighted.

Yours, etc.,

E. W. BAXTER.

Department of Biology,
Guy's Hospital Medical School.

SENEX MORTUUS EST

Weep, weep ye Muses,
For Vertue is dead.

Virtue, it is said,
Is its own reward;
Yet not since Keats
Enlightened these corridors of power
Was there such an hour
When poets might vigil keep
For one who made the love of man and wife
His life.

Suckling babe and milking mother
Comforting each, the one the other :
This to him was happiness supreme ;
The epitome of every mother's dream.

Wipe, wipe those tears
And look beyond the years,
Beyond the shadows of earth's cloud,
To where the full-flushed cherubs,
Eyes twinkling with celestial blue,
Reach out podgy fingers in welcoming embrace
Crying : "Father is come :
The father of our race."

E.W.B.

Another Side

SIR,—On behalf of the last Introductory Course, I should like to comment on several points dealt with in the main article of last week's nursing section.

I'd like to expand the term " spoon-fed " with regard to our period in the Introductory Course. We were " spoon-fed " in that we worked at lectures and practical demonstrations from 9 to 4. Added to this was two hours' home-work and extra reading. The emphasis was on adapting our schoolgirl mind to that of a nurse.

One group of five study days per ward are devoted to the connection between the practical and theoretical sides of specific diseases. This encourages, from the beginning, book work hand in hand with practical work.

For each study day we are set some research; information for this can easily be obtained from reading up books and the patients' notes, but often more useful information can be obtained from the senior nurses, who when the opportunity of asking is right, are only too ready to help and teach

We felt that last week's article made a lot of sweeping statements that could be rather discouraging to junior nurses like ourselves. We hope that this clarifies these points and puts over one side of the question.

J.S.N. J. E. ANDREWS,
Set Representative.

4th September, 1966.

59 Club

SIR,—The Annual Dinner of the 59 Club will be held at the Miller of Mansfield, S.E.1, on Saturday, 4th of March, 1967.

I will send the full details of this year's dinner to all members in due course, but if anyone has changed their address since last year, I would be grateful if they would notify me as soon as possible.

Yours, etc.,
RICHARD G. NOTLEY.

12, Gumbrell's Close,
Fairlands,
Guildford, Surrey.

Proverbs

SIR,—I find it difficult to perceive the logic in your quotation of a Basuto proverb in your recent "Passim." There is an old Burns proverb which says " If a thing is rotten, don't try to preserve it." If we were to follow your Basuto proverb, we should still have cock fighting and public executions.

Yours, etc.,
T. H. S. BURNS.

" Newlands ",
Edgehill Road,
Ealing, W.13.

[*We commend the poetic proverb quoted above, wondering, nevertheless, why we should be exhorted to confound the laws of logic. Fortunately our society, albeit unknowingly, has followed the Basuto proverb, with the result that cockfighting and public hanging have been replaced by "something of value." As to the Basutos, cocks are too valuable to put into the ring, and public executions if they occur are a well kept secret.*]

Those Valleys

SIR,—I have always derived great pleasure from a bout of spirited correspondence in the *Gazette*. I greatly enjoyed the recent exchange of views on South African politics when, believe it or not, my sympathies were with those who were against apartheid.

My anti-Welsh letter, however misguided and in poor taste, was primarily intended to stir up a little more entertainment in the correspondence section. I had thought that the views were expressed baldly and outrageously enough for it to be realized that they were not intended as a serious recommendation. I was apparently wrong.

I should further add that, if the custom of some exiles from the Principality to organize themselves, particularly on Saturday nights, into intemperate, maruding bands intent upon the disruption of the pleasure of others, has ceased at Guy's, I completely withdraw the innuendo of my unfortnuate letter and sincerely apologize to my Welsh brethren—amongst whom I used to have a few friends!

Yours, etc.,
B. A. TUDGAY.

30, High Street,
Ticehurst, Sussex.

NURSING SECTION

The Sisters' Christmas Dinner

The Sisters' Christmas Dinner was held on the 242nd Birthday of the Hospital in the magnificent setting of the Clothworkers' Hall—the sixth hall on the present site acquired in 1486.

The Sisters were honoured by the presence of The Master of the Clothworkers' Company, Sir Graham Vincent, K.C.M.G., C.B., C.V.O., who gave a brief but fascinating speech concerning the history of the Company.

In the deeply regretted absence of Lord and Lady Robens, Mr. A. E. Orchard Lisle, F.A.I.—the Vice-Chairman—introduced the speakers.

In her opening remarks, Matron expressed the warm appreciation of the gathering to The Clothworkers' Company for their generosity in permitting the Dinner to be held in their Hall. Guests were welcomed, with particular mention of Professor Hedley Atkins, D.M., M.Ch., P.R.C.S., the Sisters who had left Guy's during 1966, and Mr. W. Kingston, M.B.E.

Matron continued by stressing that Guy's could never thank the Sisters sufficiently for their tremendous tenacity and industry through the difficulties of 1966. In their turn, the Sisters realised how much they owed to Lord Robens for implementing some of the changes which had been initiated. Matron referred to two members of the Board of Governors to whom the nursing service owed a particular debt: Mrs. Iris Brook—the only nurse on the Board—a position held by her for eighteen years—and Mr. Richard Hayward, C.B.E.—a vigorous and humorous member for fourteen years!

Matron emphasised her belief that, although there had certainly been days of great concern in 1966, there had also been many events of great joy, and mentioned these, climaxing in " the news of the marriage of Dr. and Mrs. Charles Baker, which came as a Christmas present to us all!"

Matron was confident that the nursing service was on a healthier footing than for a very long time. Looking to the future, Matron Ashe quoted from the leader of *The Times* in its first edition of 1967 and also from the wisdom within the Christmas letters which she had received from Miss Margaret Hogg, C.B.E. (Matron, 1917—1927) and Miss Emily E. P. MacManus (Matron 1927—1946).

In conclusion, Matron stressed that unity of effort would carry the community forward, and the generation 100 years ahead could well say " 1967—THIS WAS THEIR FINEST HOUR!"

As Guest Speaker, Professor Hedley Atkins reminded the gathering of the great debt owed by Guy's to The Clothworkers' Company in financing the exchange schemes for Sisters and Doctors of Guy's to Johns Hopkins' Hospital, Baltimore.

In his reminiscences, Professor Atkins referred to Sisters Gale, Dobson, Arabella and Androve, and also to Miss Whittrick—great names which would never be forgotten in the history of the nursing service at Guy's.

The dinner itself was excellent, and the whole event proved such an outstanding occasion that the Sisters returned home full of hope that this might become an annual arrangement.

STAFF CHANGES AND APPOINTMENTS

APPOINTMENTS

C/N A. R. Gunn, to Cornelius Ward.
S/N A. Iverson (State School of Nursing, Oslo), to Diplock Ward

DEPARTURES

S/N E. A. Bellamy, from Casualty.
S/N A. Carter, from Surgical X-Ray Theatre.

SPORT

The death of Sir John Conybeare, K.B.E., M.C., F.R.C.P., has depleted Guy's of a most loyal supporter of sport. As a Vice-President of the Rugby Club since 1933, and also a Vice-President of the Cricket Club, he constantly appeared as a spectator whenever his health and the weather permitted. We salute him for his unfailing interest.

RUGBY FOOTBALL

Last week-end saw the Western Counties beat the Wallabies and Cornwall beat Oxfordshire, both winning sides using the advantage of a fast mobile pack and a flexible three-quarter line. Without hesitation, we can bracket Guy's into the same category, for on the same day they showed their potential against the experienced Plymouth Albion—a side containing four county players, ex-England trialist, N. Southern and Cambridge Blue, N. Thomas. Although a 3—3 draw, credit to Guy's for a display of the principles of Rugby, and pity luck was against them.

We cannot stress enough that the presence of an encouraging band of spectators added weight to the Guy's determination to win. With cup matches " at our door", we need strong support—it truly works.

On Tuesday, Guy's will have played St. Mary's in the second round of the United Hospitals' Cup. From the first round have emerged Westminster (against U.C.H.) and King's (against Charing Cross) as victors. Guy's, the holders, have to encounter St. Mary's and St. Thomas' in the same half of the draw—" our strongest challengers "—and Westminster appear as a serious threat in the other half with Rutter, Skirving and Lewis providing a powerful three-quarter line.

Stop Press :

2nd Round Inter-Hospital's Cup: Guy's v. St. Mary's: 9—14.

HOCKEY

After the exacting Christmas festivities, the Hockey Club resumed their fixture commitments and played their first match of 1967 against Romford, but were defeated 1—0.

SOCCER

1967 proved to be an embarrassment to 1st XI when they were heavily defeated by Southampton on January 11th.

Perhaps the result of St. Thomas' versus St. Mary's this Saturday in the 2nd round of the Hospitals' Cup will stir them from further impotence.

DIARY

RUGBY FOOTBALL.
Jan. 21.—Taunton. Away.
,, 28.—Devonport Services. Away.
Feb. 4.—Coventry. Away.

HOCKEY.
Jan. 21.—Tulse Hill. Home.
,, 28.—N.P. Bank. Away.
Feb. 4.—Westminster Bank. Away.

SOCCER.
Jan. 21.—U.C.H. (United Hospitals' League). Home.
,, 25.—St. George's (U.H.L.).
,, 28.—St. Mary's. Away.
Feb. 1.—St. Bart's (U.H.L.). Home.
,, 4.—London (U.H.L.). Away.

LADIES' HOCKEY.
Feb. 1—Goldsmiths' College. Away.
,, 4.—St. Bart's. Away.

CROSS-COUNTRY.
Jan. 21.—Q.M.C. " 7½ ". Brentwood.
,, 25.—Latymer Upper School. P.H.F.
,, 28.—U.H. v. Q.M.C., Reading. Reading.

Feb. 1.—5th League: Div. 1. West Ham.
Div. II.
,, 4.—U.H. v. Oxford Tortoises. Oxford.

RUGBY FOOTBALL

GUY'S v. PLYMOUTH ALBION

At H.O.P. Saturday, 14th January, 1967

Result: drew 3—3

Plymouth, who are having a successful season, proved to be stern opponents in this exciting and hard game at Honor Oak Park. The standard of play, particularly the forward interpassing movements, was high throughout, and the Plymouth defence was outstanding during the last twenty minutes when Guy's kept up a sustained attack on the visitors' line, only failing to score on three occasions by a matter of a few inches. Both sides attempted to play attacking rugby from almost all positions on the field, and the spectators were rewarded with an entertaining exhibition of rugby. In fact, fervour in the stand was to a high pitch towards the close, but even this was not quite enough to spur the team on to get the winning score.

Guy's could in fact have won the game in the opening fifteen minutes if one of a series of attempted penalties had been successful. Although one hit the posts and others went close, this was not good enough, and Plymouth began to settle down. The packs were both fast and fit and neither side got the upper hand in winning the ball from the loose. When they did do so both packs made good use of it, but it was noticeable that the Plymouth interpassing was slightly faster than that of Guy's, the movements went further and less often were men caught with the ball. Play moved from one end of the field to the other, neither side breaking through, although the less orthodox Guy's threequarter movements looked more dangerous and our back row was a continual threat to the Plymouth defence. The set scrums and the referee did not appear to agree, the end result being that Plymouth gained four or five against the head which proved dangerous on at least one occasion. In the line-out the Hospital side obtained the ball more clearly than the opposition, and overlapping around the back of the line-out led to some good movements. However, there was at times too much delay between the line-out and fly-half getting possession, and Plymouth exploited this by breaking through and dribbling on a number of occasions.

During most of the first half Guy's just had the edge, but Plymouth took command for a while after the interval, and took advantage of a scrum infringement to convert a penalty kick from half-way out near the twenty-five yard line. They maintained this three point lead until a few minutes from the final whistle when Elliott put a drop kick over following a scrum beneath the posts, this leading to a fair result of a 3—3 draw. The last twenty minutes saw complete territorial domination by Guy's, and Thorburn, Beacham and Elliott all but got through for a try.

Guy's: D. R. Elliott; J. R. M. Ross, R. J. Beacham, J. Price, I. J. Morgan; B. J. Rowlands, P. G. F. Swift; J. E. Davies, G. B. Hey, A. J. Kingdon, J. M. Cockburn, C. G. Neville, H. C. Sharp, K. G. E. Brown, C. W. Thorburn (Capt.).

S. COOK

HOCKEY

GUY'S v. ST. BART'S

At. H.O.P. Wednesday, 11th January, 1967

Result: drew 0—0

In the first game for both sides since the Christmas break, Guy's and Bart's fought out a goalless draw on a very muddy H.O.P. Considering the state of the pitch, and the toll that the holiday festivities must have taken of fitness, the game was played at a surprisingly fast pace.

A draw was a fair result to a game between two evenly matched teams; in spite of the lack of goals, there were a number of near-misses by both sides. The defence on a whole played well, with D. Crafts and Pearson having particularly good games. The forward line, though lacking somewhat in penetration, played quite well together; however, more use should have been made of several centres which passed across the face of the Barts goal, with no forward at hand to apply the finishing touch.

Guy's: N. White; M. Vellecott, D. Crafts; R. Kendrick, J. Crafts, C. Pearson; A. Godfrey, M. Appleby, N. Dodd, H. McMichem, S. Cripps.

M. APPLEBY

GUY'S v. ROMFORD

At H.O.P. Saturday, 14th January, 1967

Result: lost 0—1

For the first game of the second half of the season Guy's were at home to Romford. It was a perfect day for hockey although the recent cold weather followed by two or three days of warmer weather had produced a pitch that was soft on top over a frozen deeper layer; a difficult surface on which to play good hockey. However, neither this nor the four weeks' Christmas break were adequate excuses for the abysmal display shown by the Guy's team. To attempt to describe the game in detail would be a waste of time as it was a long repetition of the same basic faults. The forwards and half-backs must in large measure take the blame for the defeat and it was largely due to the efforts of the backs, and in particular D. Loader, that the score was as low as it was. The formation adopted by the team was such that there was a large 50 yards' gap between the forwards and the half-backs, so that any defender clearing an attack by the Guy's team had this distance in which to move before he came near enough to anybody to be tackled. Of the forwards only M. Appleby played with any enthusiasm, the other four appearing to have practically no interest in the game. The half-backs were too slow by far and showed a marked lack of desire to tackle their opponents. The backs had a reasonable game and as mentioned before D. Loader played well, although even in his case too many clearances were across the field rather than in the direction of the opponents' goal. Due largely to the efforts of Loader, N. White, in goal, was not unduly tested, and it was unfortunate that the only score came from a misunderstanding between these two in which they both stood by and watched the ball trickle over the line; each expecting the other to do something.

All in all a disappointing game, more particularly so, in that, having watched most of these players over many years, I know that they suffer from no lack of playing ability and are capable of much better games than this. I

trust that this criticism will not make them too despondent but will fire them to do better in the future.

Guy's: N. White; D. Loader, D. Crafts; R. Kendrick, J. Crafts, C. Pearson; A. Brooks, M. Appleby, N. Dodd, D. Steer, S. Cripps.

COLIN HUNTER-CRAIG

BOAT CLUB

UNIVERSITY OF LONDON WINTER EIGHTS, 1966

The training for this event had been scrappy due to exams and shocking weather conditions. The First eight had had the benefits of excellent coaching made possible by the acquisition of a new engine for our launch. The Second eight was a much improved crew with two new members who began the term as novices. The Third eight was an entirely novice crew. They had had only two outings before their race, a fault partly their own and partly due to the fact that we are finding it increasingly difficult to borrow boats. Some of our best oarsmen who had been trialling for the University and the ex-Senior four formed an eight together for the Senior division.

Thus, we entered four eights for the first time at this regatta:—one Senior eight, two Junior eights, and one Novice eight.

SENIOR DIVISION

Despite the fact that our senior eight was newly formed, it rowed confidently and strongly. In the regatta we met the London Hospital crew. Guy's led on the start under the superb stroking of Paul Goodar and a small lead was maintained over the first part of the course. However, London pulled back and for the last minute both crews were level. After a most exciting finish, which was thought to be a dead heat, the judge ruled that London had won by the almost unmeasurable distance of 1½ feet.

Crew:

Bow N. Pinkney.
2 I. Grimble.
3 M. Preece.
4 R. D. Forrest.
5 J. Pook.
6 G. Taylor.
7 G. W. H. Stygall.
Stroke P. Gooder.
Cox N. Daws.

JUNIOR DIVISION

During the week preceding this race we were arguing over the eligibility of our First eight for this division, because some of us had won the Junior fours at the Hospitals' regatta. We finally established our status and arrived fighting fit at the boathouse to row the first race of the day.

We were drawn against Imperial College second junior eight. With all credit to Imperial they hung on tenaciously down the course until Quintin, when our rating increased and we streaked away to win by 1¾ lengths. It was perhaps the worst race we had rowed together as a crew and none of us were happy about meetings Kings' College in the next round.

Kings' first opponents had scratched so that this was to be their first race of the day. It proved to be our hardest. The crew was composed of some four University trialists with some very beefy assistants. We were level, if not slightly down, on the start but very gradually we built up ¼-length lead. Complacency set in as usual in this crew and we had to have a ten to hold the lead. We managed to increase our lead to a length by Quintin, the crew striding at 36 to form a comfortable rhythm. Kings' put on a spurt for the finish and it was only with difficulty that we held them to ¼-length for a decision.

The final was to be with Imperial College first eight. It was late in the afternoon, the tide had turned and I.C. were late to the start. Thus we were shivering by the time we got under way. We established an early lead, but with the crew concentrating on their silver tankards and not the race, we did not increase the lead to more than ¼-length, which was the decision—University champions for the first time since 1956.

Crew:

Bow M. Fortune.
2 P. Moulder.
3 C. West.
4 J. Miller
5 M. Mace.
6 N. Bax.
7 A. Batch.
Stroke R. Mandeville.
Cox T. Kirk.

The Second eight had a stormy race against Q.M.C., in which they went up on the start by ¼-length and looked very promising. However, they lost this early lead and went down ½-length, ¾-length, 1-length until there was clear water between the crews. Towards the end Q.M.C. tired so that Guy's were overtaking by a foot on every stroke. Guy's could have won this race but for a lack of communication between cox and crew, not entirely the fault of the cox. Stroke did not realise that their progress to sure victory was so rapid and his spurt came too late. I am sure we can look forward to greater success from this crew next term if they can work together a little more.

Crew:

Bow P. Robinson
2 I. Skuse.
3 R. Salt.
4 M. Faulkner.
5 J. Swain.
6 A. Fenn.
7 J. Swain.
Stroke J. Osborne.
Cox M. Thomas.

NOVICE DIVISION

Our Third eight was given very strict instructions before the race to keep their heads and not to panic in the slightest way. They set off at a steady low rating, looking very smart but soon went down to a good University College and Hospital crew. Despite their easy defeat, they were one of the most attractive novice eights of the day. With the intensive coaching we hope to give them next term they should improve tremendously.

Crew:

Bow C. Wilde.
2 R. Knowles.
3 G. Barker.
4 J. Klossok.
5 D. Downing.
6 T. Gould.
7 A. Lalani.
Stroke B. Parker.
Cox R. Stanley.

MARTIN MACE, Captain
GEOFF STYGALL, Hon. Secretary.

SQUASH CLUB

Results:

Escorts—lost 0—5.
Coolhurst—lost 2—3 (Cumberland Cup).
Sundridge Park—lost 2—3.
St. Thomas's Hos.—won 3—2 (Cumberland Cup).

No one could claim that this has been a very successful season, so far; however, it has had its compensations. By defeating "Tommies" in a Cumberland Cup match, we hauled ourselves out of the relegation zone in the competition; we will probably be rather precariously placed at fourth out of the six clubs.

J. H. Newman has been continuing his successful season. He was runner-up in the British Universities Championship, defeating the Cambridge 1st string and captain in the semi-final. His entry has been accepted for the 1st round proper of the Amateur Championship—an achievement in itself, which reflects the high standard of his results this season.

On a lower plane, it is a pity that we cannot fill the fifth place in the Cumberland Cup team with a student of sufficient skill and keenness; however, we were lucky in having an obvious replacement in Mr. P. C. Shaw, an ex-Secretary of the Club, in the Hospital.

Finally, I think it is worth pointing out that there is a record entry of 34 for the Hospital Individual competition; this seems to suggest that there is a healthy enthusiasm for squash in the Hospital.

Cumberland Cup Team: J. H. Newman, E. P. Davis, J. R. Webb, P. C. Shaw, A. A. G. Thomson.

E. P. DAVIS, Capt.

HOSPITAL INFORMATION

APPOINTMENTS VACANT

GUY'S HOSPITAL, S.E.1.

Applications are invited for the post of **Medical Registrar** with duties to commence on 1st February, 1967, or as soon as possible thereafter, and appointment until 30th September, 1967. Applicants should hold the Membership of one of the Royal Colleges. Forms of application are obtainable from the Superintendent, and should be returned not later than **30th January, 1967.**

GUY'S HOSPITAL AND SOUTH-EAST METROPOLITAN REGIONAL HOSPITAL BOARD

Applications are ivnited to fill an established vacancy for the appointment of **Senior Registrar in Psychological Medicine to the Board of Governors of Guy's Hospital and the South-East Metropolitan Regional Hospital Board.** The appointment will be for four years, from 8th March, 1967, with duties at St. Olave's Hospital until 30th November, 1967, and for the remainder of the appointment at Bexley and Guy's Hospitals. The post, which will be reviewed annually, is subject to the Terms and Conditions of Service of Hospital Medical and Dental Staff (England and Wales). Forms of application are obtainable from, and should be lodged with, the Superintendent, Guy's Hospital, S.E.1, not later than **23rd January, 1967.**

GUY'S HOSPITAL, S.E.1.

Applications are invited for the post of **Senior Registrar in Diagnostic Radiology,** with duties to commence on 10th April, 1967. Applicants should hold the D.M.R.D. A higher medical or Surgical qualification would be an advantage. Forms of application are obtainable from, and should be lodged with, the Superintendent, Guy's Hospital, not later than **11th February, 1967.**

GUY'S HOSPITAL, S.E.1.

Applications are invited for the post of **Registrar in Psychological Medicine,** with duties commencing as soon as possible, and appointment until 30th September, 1967, in the first instance. Forms of application are obtainable from the Superintendent, Guy's Hospital, and should be returned not later than **23rd January, 1967.**

GUY'S HOSPITAL, S.E.1.

Applications are invited for the post of **Registrar in Endocrinology and Radioisotopes,** with duties to commence as soon as possible, and appointment until 30th September, 1967, in the first instance. Applicants should hold the Membership of one of the Royal Colleges. Forms of application are obtainable from the Superintendent, and should be returned not later than **30th January, 1967.**

GUY'S HOSPITAL, S.E.1.

Applications are invited for the appointment of **Registrar in the Department of Dental Prosthetics,** to attend on three sessions per week with duties commencing on 1st April, 1967. Forms of application are obtainable from, and should be lodged with, the Superintendent, Guy's Hospital, London, S.E.1, not later than **Friday, 17th February, 1967.**

GUY'S HOSPITAL MEDICAL SCHOOL

Applications are invited for the post of **Junior Lecturer/Lecturer in the Bacteriology Department,** starting on 1st April, 1967; applicants should hold a medical qualification. Salary range: £1,400—£2,535 according to qualifications and experience (subject to review). Forms of application are obtainable from the Dean, Guy's Hospital Medical School, S.E.1, and should be returned not later than **4th February, 1967.**

GUY'S HOSPITAL

March 1st, 1967

Applications are invited for the following house appointments due to begin on March 1st, 1967. Applications, giving choice of post in order of preference, to be lodged with the Superintendent, not later than **January 27th, 1967.**

House Surgeons 4
House Physicians 4
Gynaecological House Surgeon 1
Throat and Ear House Surgeon 1
Orthopaedic House Surgeon 1
Children's House Physician 1
***House Physician to Dr. Bishop, Dr. Wayte and* Mr. McArthur** 1

The above appointments will be for six months and will be open only to pre-registration candidates applying for their first appointments and **not** to candidates seeking their second six months appointment.

Resident Obstetrician
(Post-registration) 1
Neurological House Physician
(Post-registration) 1
Dermatological House Physician
(Post-registration) 1
House Physician in Child Psychiatry
(Post-registration) 1
Children's House Physician at the Evelina Hospital
(Post-registration—to commence 1.4.67) 1
Casualty Officers
(S.H.O.) 3
House Surgeon to the Thoracic Unit
(S.H.O.) 1
House Physician in Clinical Pathology
(S.H.O.) 1
House Physicians in Psychological Medicine
(S.H.O.) (To commence 1.4.67) 2
R.M.O. in Nuffield House
(S.H.O.) 1
Resident Anaesthetists
(S.H.O.) 2
Casualty Officer at the Evelina Hospital
(S.H.O.) (Part-time, six mornings a week) 1
Gynaecological House Surgeon at St. Olave's
(S.H.O.) 1
House Physician in General Medicine at New Cross
(S.H.O.) 1

R. J. CANN,
Acting Superintendent

CHANGES OF ADDRESS

Dr. N. Harper, 80, Bury New Road, Prestwich, Manchester.

Dr. and Mrs. E. Moran, 2, St. Regis Close, Alexandra Park Road, London, N.10. (Phone: 883-4562.)

DEATHS

GARLAND—On 4th January, 1967, at his home, 13, Elm Avenue, Ealing Common, W.5, Gordon Willie Garland, O.B.E., M.D., F.R.C.O.G., Obstetric Physician to St. Thomas's Hospital. (Guy's 1938—1943.)

HABBESHAW—Constance, S.R.N. (aged 60 years) died on 6th January, 1967, at the Royal Devon and Exeter Hospital. A trainee of the Guy's Hospital School of Nursing from 1929-32, re-entered as a staff nurse on 2nd June, 1933, and was promoted to sister in 1934.

THOMAS—On 6th October, 1966, Richard Vincent Lloyd Thomas, M.B., B.S.Lond., D.A.Eng., aged 46 years

BIRTHS

DAVIES—To Judith (née Harries, S.R.N., S.C.M., Part I), wife of Dr. George Rhys Davies, M.B., B.S., M.R.C.S., L.R.C.P., of 29, Warwick Road, Sketty, Swansea, a daughter, on January 3rd, 1967.

VARNEY-BURCH—On 1st January, 1967, at the Hainault Maternity Hospital, to Michaeal (L.D.S., R.C.S.) and Norma, a son—Adrian—a brother for Guy. Happy New Year!

We would like to remind our readers that all copy for inclusion in the Gazette must be received eight *days before the publication date.*

Birth, Marriage, Death and Change of Address notices are without charge to subscribers. For Personal notices the charge is £1 1s. 0d. for 15 words, additional five words 10s. 6d. minimum 15 words. Non-subscribers will pay £1 1s. 0d. for all notices other than Personal

GUY'S HOSPITAL GAZETTE

EDITORS D. S. ROBINS and C. B. BROWN
SPORTS CORRESPONDENT J. G. PAYNE
NURSING CORRESPONDENT E. A. MALPAS

FORTNIGHTLY TWO SHILLINGS VOLUME 81 NUMBER 2049

PASSIM

Habits

Amidst the justifiable clamour that medical students are not taught much about general practice it is noticeable that at least one of the most widespread of G.P. activities is only too well known—the art of disposing of free publications before reading them. Such publications are often held to be anxiously claimed by students, and the rash of such material that has erupted at the entrance to the Spit in recent months would seem to support this. However, there lurk in the Wills Library innumerable copies of Guy's Hospital Reports which are available for clinical students, four volumes every year. It is with some dismay that we learn that the majority of clinical students do not collect their copies, thus seemingly trying to outdo the G.Ps. by discarding material even before it appears. Do they not know about this, or can it be that appearing outside the Spit does something to a free publication that editors have not yet fully appreciated?

Social Responsibility

Modern democracies are, in the main, constructed so that any force for change is allowed to express itself without fear of reprisal which one equates with an authoritarian régime. In this country, freedom of expression is regarded as one of the greatest achievements of British political evolution; more simply it has been found that it is in the public interest to allow a man to shout his head off than to shoot a head off. Thus by being free to express one's disapproval or antipathy of certain social evils to the authorities responsible for reform one is able to channel one's aggression into a socially acceptable form without recourse to violent demonstration or revolution. This facility of being able to criticize freely acts as a catharsis—expunging, to a limited extent, the strong feelings and *pari passu* diminishing the motivation that fires the socially conscious.

Now the Medical Profession is in a very unique position in experiencing *its* social catharsis—every day in the consulting room, the outpatient clinic, on the ward-round and in the operating theatre. The doctor returns home to his family every night knowing that not only has he provided an absolutely essential service to the community in

helping to maintain its standard of "health", but more important, that he has helped to relieve pain and suffering or that he has saved a person from possible death. In fact he has, according to his friends who are in business, a very satisfying and rewarding job.

The profession has weaved about itself a constricting fabric that has enmeshed it to the extent that its self-consciousness has reached an all-time high. A closed society of fellow "healers" has arisen in which the important functions are to maintain the honourable reputation, and to give a wide berth to all social controversy in the name of scientific neutrality.

The contact the doctor has with society is mostly a personal one—the patient; but the ills of society are not the summation of the ills of its members. Yet one of the basic tenets of British clinical teaching is that the patient is not a diseased organ but an individual in a particular environmental setting.

Where are the Profession's spokesmen against the social ills? Does it even consider some of these problems as partly within the bounds of their expertise, notwithstanding some of the B.M.A.'s reports on the more sensational issues?

Does it not consider itself to be partly responsible for social reform?

"Well that's not for me to say. I only try to do my best to help my patients live longer and to relieve pain and suffering where I can."

A Plea

A letter on page 71 raises a plea along similar lines to one of our own during October last. The memories which old Guy's men have of their student years incorporates not merely the surroundings and the relatively established personnel; these memories are intricately woven about their contemporaries. While efforts are made to improve our coverage concerning hospital developments, and these efforts being re-exerted at the moment, our knowledge of those Guy's men who have left our little parish (sic) is considerably more difficult to come by. Response for material for our proposed section, "News of Old Guy's Men", has unfortunately been disconcertingly minimal. Were we persuaded that something in the training here disciplined us in the art of maintaining contact with contemporaries we would desist, but then so would the letters and pleas referred to.

It may be the age of Bond in entertainment, but surely the medical progeny of Guy's does not really aspire to the seal of secrecy.

New Chest for Chests

A profusion of moist sounds, with complimentary fremitus reverberating around the grey, distinctly mottled walls . . . *Enough, no more, 'tis not so sweet now. . . .* With the blue and gold ribbon deftly cut by Sir Geoffrey Marshall, the dramatically transformed Chest Clinic was opened last week.

On behalf of many we would like to express our warmest thanks to Mr. R. J. Cann, who is retiring from the post of Acting Superintendent which he has held for the past year. He will now be returning to his duties on the Board of Governors. We welcome Dr. P. J. Helliwell as the new Superintendent and wish him the best of success with this onerous task.

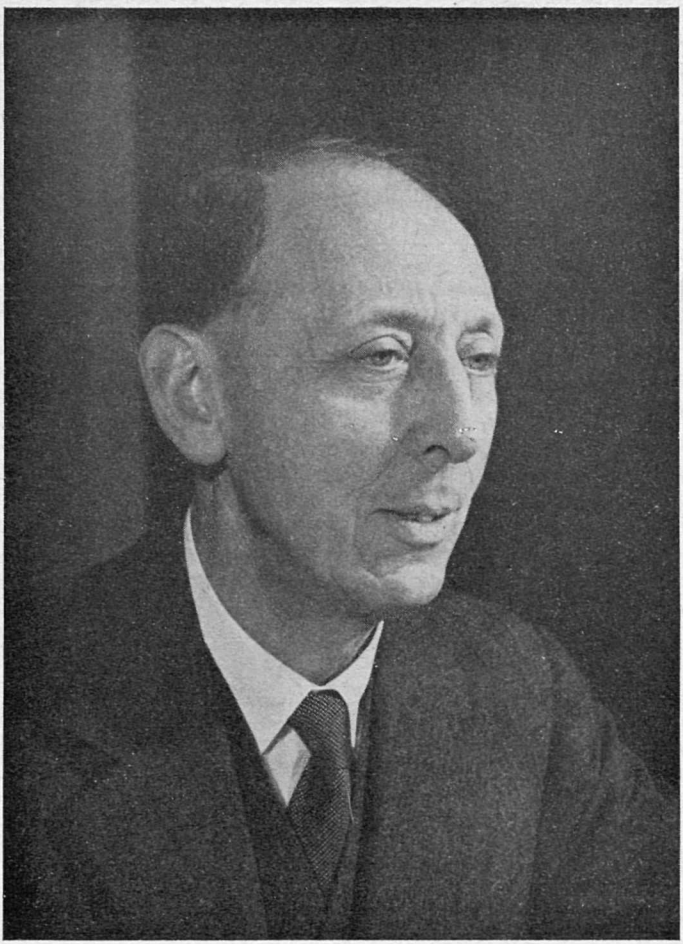
We congratulate Dr. Maurice Lessof on his appointment as Consultant in Clinical Immunology at Guy's.

As we go to press we are sad to hear of the death of Dr. Geoffrey Rawson. A tribute will appear in our next issue.

At the recent Gazette Committee meeting the Committee regretfully accepted the resignation of Mr. Gibberd from the Chairmanship. He has acted as Chairman since the retirement of Dr. Maurice Campbell, and his advice and help will always be remembered by those editors who served during his term of office. Dr. C. G. Baker was elected as the new Chairman. Mr. Colin Brown, ex-editor of *Intermedica* and the *British Medical Students' Journal,* was elected Assistant Editor.

GUY'S DIARY

JANUARY			EXHIBITION in The Gordon Museum—BURNS.
6th	M.	1.00	Clinical Lecture. Mr. CRABBE. "Surgical Treatment in Rheumatoid Arthritis."
7th	Tu.	1.00	Clinical Lecture. Mr. BLACKBURN. "Crohn's Disease."
9th	Th.	1.00	Clinical Lecture. Dr. HOARE.
		5.00	Neurosurgical Round. Mr. MURRAY FALCONER. In the Clinical Theatre: Demonstration of two cases.
13th	M.	1.00	Clinical Lecture. Dr. FORMAN. "The Cutaneous Signs of Malignant Disease."
14th	Tu.	1.00	Clinical Lecture. Dr. MacKEITH. "Recurrent Abdominal Pain."
16th	Th.	1.00	Clinical Lecture. Mr. LAWRIE. "Neonatal Obstruction."
17th	F.	1.00	Clinical Lecture. Dr. HELLIWELL.



W. M. Mollison, C.B.E., M.Ch., F.R.C.S.

It was with sadness that we heard last week of the death of Mr. W. M. Mollison. To many of today's Guy's family this will only mean the passing of a famous name, for it is 28 years since he retired from the Guy's consultant staff at the age of 60. But for many older Guy's men and women, many of whom were his admiring students, there will remain the memory of his charm, his quick, alert and skilful activity everywhere he went in the Hospital to which he devoted his life. For nearly 65 years Mollison was associated with the Hospital

and the School—as a student, house officer, junior member of staff of School and Hospital, consultant ear and throat surgeon, chairman of committees and only resigning as Chairman of the Medical School Governors when an accident in 1965 limited his travelling and mobility.

Mollison came to Guy's in 1901 as a clinical student from Cambridge. His father was master of Clare College, so it was natural of his son to choose another, and he proceeded from Haileybury to King's College, where he became an exhibitioner and prize-man. He obtained a First in Natural Science Tripos, and with this reputation it is not surprising to find his student card at Guy's filled with the highest marks for each of his student appointments. He qualified in 1904 and within two years obtained the M.Ch. Cambridge, and a month later F.R.C.S. In 1904 out-patient officer was a new appointment, and after qualification Mollison was chosen as one of the first group. Later he became house surgeon and then had the unique experience of being the last house surgeon to Jacobson and the first to Arbuthnot Lane, when he became a full surgeon. He often remembered that he had served under one of the most able of Guy's surgical teachers and under one of the most famous of Guy's surgeons. For the next few years he held a number of junior staff posts in Hospital and School. He was a demonstrator of anatomy—the customary stepping stone to the surgical staff—he was a tutor to dental students and an anaesthetist to dental out-patients. He was Warden of the College and significantly became a clinical assistant in the Throat Department under Mr. Steward. At this time the special departments for throat and ear work were in the charge of the assistant general surgeons, in turn, who relinquished these appointments when they became full surgeons. In 1910 Mr. Fagge, in charge of the Ear Department, decided to relinquish his special work, and the Governors decided to appoint a specialist and not to offer the vacancy to another assistant general surgeon. Mollison was appointed and thus after a long interval, Guy's again had an aural specialist. In 1912, Steward was promoted to full surgeon and then the hospital Governors decided to join the Throat and Ear Departments and to create a combined department which we have had ever since. Mollison was joined by T. B. Layton, and they became the first two surgeons in charge. It would be difficult to find two chiefs more different in temperament or in clinical interest, yet they were as one in their devotion to the Hospital and in their desire to train others. Their very contrasts made for a wonderful nursery for the future of the speciality. If one could have had a choice, the ideal was to serve one's first apprenticeship with Layton and to have acquired the finesse and polish from Mollison. The junior staff under each surgeon was a chief assistant part-time, and a house surgeon. To be the latter was always a worthwhile experience and started many a career, but to attain the former was success indeed, and led invariably after some years to a specialist appointment, often in another teaching hospital.

It was Mollison's technical skill in operating and in the examination of patients that contributed to the speed at which he worked. This, however, never detracted from his results, but it was this attribute which made attempts to emulate him so dangerous for the novice. He was frequently visited by surgeons from home and abroad. On one occasion two American visitors watched almost breathlessly as he used hammer and gouges to produce the perfect and aesthetic radical mastoid cavity. "Say", said one, "how do you manage to do it so fast?"—no doubt wondering how the facial nerve had survived the onslaught. "What? What? Just know your anatomy" was all they learned. Mollison lived and worked through the heyday of mastoid surgery when acute mastoiditis was an emergency, and chronic suppurative ear disease a menace. No antibiotic aids existed to permit waiting and watching or to hide one's mistakes. Every case of acute middle ear infection needed the best of one's clinical judgment and action. He was sometimes described as a lucky surgeon, but luck is not a feature of medicine or surgery. Its seeming existence is evidence of that little more in skill and experience.

In his teaching in Out-patients or by lecture, he delighted in rapid and artistic sketches, and sometimes by the aid of ingenious cardboard models which he made himself, often during the evening before. His famous working model of laryngeal muscles helped many to understand hoarseness and stridor, and to do

so in minutes rather than after half-an-hour's talking and drawing. In all he did he revealed an artistic background. In his home he possessed a large collection of water colour drawings, and with his violin took part in many evenings of chamber music in that large back room in Devonshire Place. It is this large back room that many members of the Guy's staff will remember as the meeting place of the Medical Committee. Those were the days when the Medical Committee was small enough to fit into a private home, and it was said that the possession of such a room was a strong point in the choice of Chairman! However, it would take a week for the soft furnishings to give up the aroma of cigars and any chairman also needed to have a most indulgent and understanding wife and family. Chairmanship of the Medical Committee meant also being Chairman of the School Council, which service Mollison gave to the School till his retirement in 1938. Two years later he became a Governor of the Medical and Dental Schools and was elected Chairman of the School Governors in 1948 till his resignation in September, 1965.

In the wider spheres of his speciality he was highly regarded and respected. He was President of both sections of the Royal Society of Medicine—Otology and Laryngology—an unusual distinction. He was one of the Founder members of the first of the travelling clubs in the speciality. Its official title was the Visiting Association of Oto-laryngologists of Great Britain, and had a limited and distinguished membership. Envious non-members called it the "travelling circus" until the idea spread and many other travelling clubs were formed. At the beginning of the last war Mollison was adviser to the Government on the grading and allocation of ear and throat specialists. After the war he entertained each year at his home the Semon Lecturer and made this the occasion for inviting a large number of his friends and colleagues in the speciality.

In his writing and in his public speaking he was a person of few words, never allowing a waste of unnecessary descriptive trimmings. In fact it often seemed that he was producing a precis of what he wanted to say. This was in tune with his physical activities—always full of energy, never wasting time, round the corner and gone before one realised he was going. Yet there was never any rudeness in this and he was never heard to speak ill or critically of anyone. His charm, his fairness, his kindness and his self-effacement could only make him loved by all. He was always generous, not only in the accepted ways and at the appropriate times, but on occasions more ingeniously and surreptitiously. When a private patient felt unable to afford his usual operation fee, he would adjust matters, but sometimes he suggested another "surgeon who would be willing to charge less." This other surgeon invariably was his assistant who knew nothing of the arrangement until asked if he could operate on the morrow on a patient going into the private ward today. At one such request his assistant begged to be excused as he was due to go on holiday. "Oh! Really, are you? Well, never mind, you operate and I will look after the patient until you come back." Of course, he knew the assistant was going on holiday and of course he knew that the salary of his assistant was £150 per annum.

Mollison had a large private practice, which he conducted from his home. His consulting room was also the family's sitting room, and its furnishings and equipment was an understandable mixture, yet seemed just right. Someone gave him a small carved ivory elephant. It was put on the mantlepiece in the place of honour. This attracted other gifts and in time the mantelpiece was covered with ivory animals. Delightful pastel portraits of his children hung on the walls. Mrs. Mollison would come in and supervise tea. Mrs. Mollison died last Christmas Day, so it has been a doubly sad time for the children. We send them our deepest sympathy, but they, as do his students of all ages, remember Molly with love, admiration and thanks.

A Student View of General Practice

by G. A. Machin

As my last student appointment before qualifying, I was fortunate in being able to spend two months in general practice. This gave me sufficient time to become well acquainted with the way the practice is run, and, by the end of eight weeks, I knew some of the patients quite well. I shall record here some of my impressions of general practice as I saw it in the practice I visited, and also speculate on the future of general practice as an integral part of the N.H.S. My views are highly coloured by the fact that, as things stand at present, I have every intention of being a general practitioner. I feel strongly that there is a great future for general practice. This future can only be fulfilled if there is a radical change in the way G.P. is regarded by the medical profession as a whole and, particularly, by those who are responsible for the conditions under which family doctors have to work at present.

The Function of the G.P.

There seems to be little doubt that general practice, in some form or another, must persist. The dwindling number of G.Ps. in this country is, therefore, a matter for real concern. The value of the G.P. in the medical care offered to the community can only be truly appreciated where there are no G.Ps.

It is clear that there must be some type of doctor who can act as the first contact between the general pool of diseased patients and the diagnostic and therapeutic facilities of the Health Service. Perhaps the philosophy behind the idea of the N.H.S. is that anyone who feels in any way that his mind or body is to any extent diseased, should be able to see a doctor about it. In an advanced community such as ours, there is no reason why people should be ill and miss work or play when it is quite possible to cure or alleviate many trivial or severe illnesses.

But it is not the corollary that the G.P. is therefore a specialist in trivia. Certainly, one must provide for trivial illnesses, which may, even so, cause considerable misery. But the thing which impressed me

in the practice was that there was a great deal of non-trivial illness of the kind which the student sees in hospital. I saw three cases of D.S., many cases of carcinoma, with all the attendant problems of support and terminal care, several urinary tract infections and some interesting paediatric illnesses. There was also a good deal of psychiatric care being given, and, although a lot of this went under the heading of "neurosis" and consisted of all the post-menopausal suburban housewives suddenly finding out how narrow their lives were, there were some seriously ill patients, including one who was hypomanic if not manic. In all this, the practitioner has to separate the trivial from the serious, recognising (a) that helping with the trivial complaints is a very great service to the community, and (b) that the serious illness may often present with trivial signs and symptoms.

The next question is whether the G.P's. function is or should be merely that of a filter, referring some patients and reassuring the majority with symptomatic treatment. Alas, this is often the case at present, and I think the reason for this is that the G.P. is considered to be the poor man's doctor, the second-class doctor, the doctor who did not succeed in the hospital rat race. In a good many cases this is so, but there are also excellent doctors who are in general practice because this is what they want to do. They are every bit as competent as their counterparts in the hospitals, they read the medical literature and are thoroughly *au fait* with current medicine. But, by convention, precedent and prejudice, they are second-rate doctors. They are either denied access to hospital diagnostic facilities or else they are allowed to use them very much on sufferance and have to be careful how many X-rays and pathological investigations they request. The hospitals are the monolithic victors in the field and the G.Ps. are the reeds bent by the wind.

Access to Hospital Facilities for Investigation

Clearly, this is no way to approach the problem of patient care. After all, it is the health of the patient about which we are, or should be, concerned, and, if a registered medical practitioner feels that an investigation is necessary, such an investigation should be performed, regardless of whether the request comes from a consultant or a G.P. It seems odd that the requests for investigation by a doctor who qualified perhaps a few days or weeks previously should be accepted without a murmur, while the request made by a G.P. who has practised good medicine for 20 years should be accepted grudgingly or not at all. Many patients are admitted to medical beds "for investigation". Many of these investigations involve no more than a venepuncture and, indeed, a patient may occupy a bed for a week, for a cost of about £50, and all that will be done is two or three venepunctures and a couple of X-rays. Immense amounts of money could be saved if a G.P. could feel free to order these investigations before ever referring the patient to the hospital. It is argued that a free access to these facilities for G.Ps. would mean a greatly increased load of work. This, again, presumes that the G.P. is a second-rate doctor who would use facilities indiscriminately and to excess. I do not believe

that this would be the case. I would prefer to argue that, should the work load increase, this would show that necessary investigations were not being done before because the G.P. was denied access. In any event, investigations done by the G.P. would then not have to be done by a consultant to whom the patient was referred, so that the work load would not be greatly increased. Even investigations which yield normal results are extremely valuable, as they enable a profile of the patient to be built up and any future repeat investigation can then be compared with the previous one.

I think that this question of G.P. access to diagnostic facilities is one of the basic ones. Medical students are taught all about these investigations and are then thrown into general practice, where access to investigation is promptly withdrawn. Any doctor worth his salt will wish to investigate his patients as far as he reasonably can in order to have the satisfaction of making a provisional diagnosis. After this he can then decide whether he can manage the patient himself or whether he should ask for assistance from a specialist. Much valuable consultant time could be saved if G.Ps. were able to decide for themselves that there is little wrong with a patient. Often, he has to refer the patient in order to have an investigation done which then shows nothing wrong. This does little for his ego or his reputation with the consultant.

I am convinced that hospital doctors and administrators must rid themselves of prejudice and accept the G.P. as a competent, valuable and integral member of an organization which exists to serve the patients. This is not the case at present, but the hatchet of medical class warfare must be buried.

One of the most fascinating aspects of general practice is that one practitioner is able to see a patient in profile over a number of years. This not only enhances his appreciation of human nature in general but it also means that he can study disease in profile. He gains a good idea of the natural history of disease, and, as an interaction between personality and disease, is perhaps able to decide whether or not a patient is ill, judging by his previous knowledge of the patient. Clearly, this can be dangerous, as with the patient who cries wolf. But, in many cases, it is an immense advantage.

Terminally, it is often the G.P. who finally has the diagnosis, and finds out that wise heads in hospitals were wrong. This gives him a wiser head and also raises the question of whether consultants would like to be told of the fate of patients whom they see briefly and in whom the diagnosis may be doubtful. It would surely increase their experience and help them with future doubtful cases if the G.P. were to tell them the ultimate diagnosis.

G.P.—Hospital Relationships

Since the G.P. must be accepted as an integral part of the N.H.S., the question arises as to how closely he should be concerned with his

patients when they are in hospital. Under the present system, the patient's case is passed from the G.P. to the consultant when the latter agrees to take the patient into hospital. Once the patient is in, the G.P. will hear nothing until he is either asked to inform the relatives that the patient died or is in possession of a brief note stating that the patient has been discharged and that a longer account of the admission will follow. After a variable interval, it does follow.

As a G.P., I would find this unsatisfactory in the extreme. Having pursued the diagnosis as far as I could, I would be keenly interested to know how my patient was progressing. At present, the only way to find out is to telephone and pester the staff. I should have thought that it should be a rule that the G.P. concerned should be informed on the same day by postcard when any surgical or major investigative procedure is carried out on the patient. And where a series of investigations reveal a hitherto obscure diagnosis, I think the G.P. should know about this at the earliest opportunity.

The next logical question is whether the G.P. should take any part in the hospital service himself. At present, the only person-to-person contact between G.P. and consultant is during a domiciliary visit. Frequently, this is hardly a suitable setting for the discussion of the finer points of the case. If a patient is in hospital it would seem obvious for him to be visited by his G.P. and for the G.P. and consultant to discuss his case while he is in hospital. This would surely be more satisfactory than the formal letter, sent some little time after the admission.

From this arises the question of whether the G.P. should himself have some beds in a hospital, in which he could manage some of his patients. There would, admittedly, be the patients who would occupy the beds for social reasons more than any other, and some patients with cardio-respiratory illness would occupy them during the winter. Nevertheless, there are cases which G.Ps. would like to be allowed to manage themselves. Knowing their own limitations, there would be great satisfaction in going for and making a diagnosis, and then managing the patient, with a consultant ready to give advice as required.

From this it is not a far cry to the concept of a doctor who is a G.P. for half the week and a consultant for the other. This would be possible in larger group practices if the number of patients per doctor were reduced so that the daily work load could be carried by the other partners while the doctor in question did his hospital sessions.

If the G.P. is to spread his interests and follow his patients more closely, he must do two things. He must have his practice superbly organized and he must contract certain spheres of action which are at present his by inheritance from a bygone age.

Administration of the Practice

With regard to organization, there is probably a great deal the average G.P. can do for himself and there is certainly a great deal that should be done for him by the administrators of the N.H.S. The G.P. can help himself by educating his patients so that he is only called upon when necessary. Trivia can be cut down in this way and the doctor tends to forget just how little a layman can know about illness. Five seconds telling a patient that there is very little that can be done about 'flu apart from going to bed, is time well spent. It is also clear that a great deal of time can be saved if patients come to the surgery rather than asking for a home visit. Clearly, there are times when a home visit is necessary, but it has been shown that active attempts to reduce home visits can succeed without any deterioration in the quality of medical care. A surgery is equipped to receive and examine patients but the average home is not. The doctor should not be expected to "deliver daily" like the milkman or the baker. He has, on average, 2,500 patients to look after and it is for the individual patient to co-operate whenever possible by going to the surgery.

Much the same considerations apply to night visits. These are in any case rare, contrary to popular belief. To function adequately, a doctor needs as much sleep as anyone else if he is to work a normal day. He cannot carry his practice 24 hours a day and it is extraordinary that so many people feel that he should and that he is prostituting his art by trying to work a nine-to-nine day.

Another aid which a G.P. should have is an appointment system. This also has huge advantages for the patient. If he has a book which says he will see patients between 9 and 11, he will be clear of the last by 11.30 and off on his round. At a rate of a patient every 7 minutes or so this works very well. There is bound to be the odd occasion when he is called out to a coronary and the whole scheme goes for that session, but this is a risk worth taking. It is a curious thing that general practice works very much on a supply-and-demand basis. If there is no booking for a patient, he is usually content to leave it until tomorrow, i.e. there is a high but not serious morbidity. When a doctor goes away on holiday, patients would rather put up with their symptoms than see a locum, although the resistance may break down by the end of two weeks. The system pares itself down so that "x" patients are seen during a week and there are none who should have been seen but were not. The appointment system allows the doctor to regulate his time and vary his routine so that he does not become a slave to his practice.

Finally, the G.P. helps himself greatly by keeping records. A suitable set of abbreviations and diagrams can give an excellent picture of the patient's health, and records of hospital admissions can also be quoted.

The keeping of an appointment system and the organization of an adequate system of records requires adequate secretarial help, and

this brings out one of the main legitimate grumbles of the G.Ps. This is the fact that the G.P. has to provide his own facilities and help whereas the hospital doctor has these provided by the N.H.S. This ludicrous situation will soon be changed, one trusts, and G.Ps. and their wives will sleep easier.

Really well-organized secretarial and ancillary help in all adequate premises would leave the G.P. free from the more routine administrative side of his patients. It would enable him more clearly to see the large issues, the patterns of disease, the comparisons between various treatments. Instead of being a long, rushed, empirical and highly unsatisfactory way of trying to keep abreast of a large and seemingly endless series of individual problems which dictate his whole mode of life, the G.P. would have his practice under control, be able to deal effectively with his patients, draw definite conclusions from the way in which he treats them, and lead a private life somewhere approaching normality.

G.P. Obstetrics

As mentioned, he must contract his interests in certain fields. As more sophisticated methods of diagnosis develop, and as more medical methods of treating disease arise with the development of the pharmaceutical industry, so the interest of the G.P. in surgery has diminished. He must clearly have some small practical skill in minor casualty surgery but, for the rest, there are surely other things with which he can better occupy himself. It is no longer necessary for the G.P. to convince himself that he is doing a good job only if he has blood on his hands. Many feel that the same should apply to obstetrics. Much has been written about the place of confinement recently and I cannot enter into this. But, as Russell[1] has pointed out, the method of reproduction may appear to be efficient overall, but it is not very kind to the individual. It is the individual with whom the G.P. deals, and the very existence of the Flying Squad Service is a tribute to the dangers inherent in obstetrics. Unless a G.P. does a very great deal of obstetrics he cannot possibly have enough experience or skill to deal with the difficult delivery when it presents. To have a G.P. obstetrician in a partnership of 5 or 6 is reasonable, to cater for the needs of patients who feel strongly that they would like to be delivered at home. But I do not think it should be *de rigueur* that a G.P. should be able to do some obstetrics if required. It is more than likely that he will merely interfere and be meddlesome. It would be far better to leave obstetrics to the midwives and ask to have patients admitted when necessary.

Russell points out that the figures for confinement at home and in G.P. units do not compare well with confinement in a fully equipped obstetric unit, with regard to perinatal mortality in particular. Hobbs and Acheson[2] found that the perinatal mortality in nulliparae booked for consultant care and for G.P. care was almost identical despite the selection of unfavourable nulliparae for consultant care. In addition, 16.5% of mothers booked for G.P. care had to be transferred to

consultant care late in pregnancy or in labour. This paper must surely settle, once and for all, the question of the place of confinement for the first baby.

But even in pregnancies where there is no reason to think that hospital confinement is absolutely indicated, things can go badly and rapidly wrong during labour. It is a tribute to the great hazards of the extraordinary way in which the human species reproduces itself, that the following facts apply to my edition of Ten Teachers' "Midwifery": the first 95 pages are concerned with a revision of the anatomical and physiological facts of reproduction, which are available in all standard anatomy and physiology texts. The next 60 pages are concerned with the normal pregnancy, labour and puerperium. The next 426 pages are devoted to the pathology of pregnancy, labour and puerperium.

It is for this sort of reason that I am rather alarmed by Mr. Brown's article[3] on the "G.P. Obstetrician", earlier in this series. The figures look quite impressive *en bloc,* but, on looking more closely, one finds the following figures: 11,713 deliveries in 6 years were managed entirely by 75 G.P. obstetricians. This works out at one delivery per fortnight. Is this often enough? And, since it seems likely that some of those 75 G.Ps. would be much keener obstetricians than others, some G.Ps. must have been managing considerably less than 26 deliveries per year. Only seven babies were lost. If one of them had been his own, perhaps he would feel differently.

Having contracted his interests and ceased to be a "general practitioner-surgeon-accoucheur" and having organized the secretarial side of his practice, how will the newly liberated G.P. spend his time?

G.P. Research

Apart from the increased possibilities of investigating and treating his patients more thoroughly and of joining in with hospital medicine, he should perhaps spend a good deal more time in self-analysis. Astonishingly little is known of the mechanics of general practice or of the ways in which patients are treated by their G.P. At the moment there are 2,500 practitioners all working away madly with their own favourite methods and medicines, mostly used to alleviate symptoms. What is needed is an attempt to try to find out which, if any, of those methods works. In other words, G.Ps. must run series, write papers and attend meetings. They can thus improve the standard of their patient care as well as stimulating their own interest in advancing medicine. There is no reason why hospital doctors should be the only ones who contribute to the progress of medicine. Nor is there any reason to think that G.Ps. are incapable of doing their own research. They have great opportunities with large quantities of good material readily to hand. But they must be freed from some of the more mundane duties of the practice which, in any other profession, are dealt with by secretarial staff.

Hand in hand with academic general practice will go increasing involvement with preventive medicine. This will require especially good and thorough education of the public, for there is at present a solid group of patients who are resistant to change and do not consult their doctors except in dire emergency, will not use contraceptives and will not have their children vaccinated. Some of these are cranks but the majority are merely poorly educated. There is a very great deal which can and should be done for social class V. At present, it is hardly possible to make contact with them at all.

Group Practice

There is great interest in this subject at present, and it is closely related to the question of health centres. I will say little about it here. It does seem to me that, with certain exceptions, the single-handed practitioner is in a poor position, both in the running of his practice and in his private life. Undoubtedly, some G.Ps. do feel that they are not justifying their existence unless they are fully in charge of their patients, busy with their needs for many hours a day and capable of a moderately good standard of acute medical treatment, minor and intermediate surgery, obstetric and anaesthetics. Such a G.P. must be of superhuman constitution and have great self-confidence. There are situations where this sort of practitioner is required, and Dr. Bullard's article[4] in a recent issue of the *Gazette,* illustrates this.

On the other hand, there must surely be increasing room for a quieter sort of G.P. who is keen to make sure that his methods of diagnosis and treatment are adequate and who aims to prevent the acute emergency, as far as is possible, rather than acting heroically when confronted with the emergency itself. How many early carcinomata are missed by the tired G.P. who would be the fresher for not having delivered a couple of babies and done a gastrectomy?

I would like to thank Dr. John Fry, in whose practice I spent a most interesting elective appointment. He showed me how stimulating the life of a family doctor can be and I am most grateful for his kindness.

REFERENCES.

1. Russell, J. K. (1966), Lancet, T., 1,315.
2. Hobbs, M. S. and Acheson, E. D. (1966), Lancet, T., 761.
3. Brown, D. (1966), Guy's Hospital Gazette, 436.
4. Bullard, J. A. (1966), Guy's Hospital Gazette, 588.

REVIEWS

CLINICAL SURGERY: THE HAND.

Edited by R. G. Pulvertaft. London, Butterworths, 1966. Chapter on Contractures of the Fingers, by P. W. Clarkson.

After publishing their illustrated textbook, "Operative Surgery", the general editors, Charles Rob and Rodney Smith, are now producing a series entitled "Clinical Surgery".

The volume on "Hand Surgery" has appeared this year under the editorship of Mr. Pulvertaft, and many surgeons of international eminence have contributed. Detailed descriptions of operative technique have been omitted, but other aspects of hand surgery are fully discussed.

Particularly valuable contributions are included from Napier on the functional anatomy of the hand and from Vaughan Jackson on the management of the rheumatoid hand. A chapter from Paul Brand on the hand in leprosy reminds us of the importance of this disease outside Britain. A fuller exposition of finger-tip amputations would be useful, particularly in view of their economic importance.

This book is handsomely presented and well but not profusely illustrated. A final fellowship student will find it very helpful, and at 97s. 6d. it should find a place in every hospital library.

A. L. GUNN

ANATOMY OF THE HUMAN BODY.

by R. D. LOCKHART, G. F. HAMILTON and F. W. FYFE.
Faber and Faber, 1966.

The first words of the preface read: "To lighten the burden of the student of anatomy is the purpose of this book." Although this is a difficult undertaking, this book certainly makes the burden more comfortable to carry.

The most obvious and welcome feature of the book is the enormous number of illustrations, many of them actual photographs (950 illustrations in fewer than 700 pages). The illustrations are clear, vivid and fully labelled, with a concise, no-nonsense text accompanying them. The relationship between structure and function is continually emphasised, so that one gets the reassuring feeling that there is some point in learning what would otherwise seem to be irrelevant details.

All the systems of the body receive adequate and accurate coverage, but the section on the nervous system is particularly good. It is clear, abundantly illustrated and easy to follow. As a large standard book such as every student needs, it is admirable. It is shorter than many standard texts, while containing the necessary detail. It is quick and easy to refer to when one wants to clarify a single point. There is no need to read through reams of print; as the information is usually readily available in a picture.

However, the biggest advantage of this book is that it is readable. All too often a session with one of the larger anatomy books does nothing but confuse the student and convince him that he is far too stupid ever to learn what is required. Although this book makes no attempt to help the student learn (as in Grant's "Method"), its clear language and lack of miles of uninterrupted text make the study of anatomy considerably more pleasant. And the flashes of dry humour are a welcome relief.

The price of this book is six guineas, which is reasonable, especially considering the number of illustrations. As a standard reference text for 2nd M.B. anatomy, it is well worth the price.

M.T.

RESPIRATION,

by Pierre Dejours. Translated by Leon Fahri. Published by Oxford University Press. *Price* 32*s*.

This is an admirable book. It is intended for those beginning physiology and the initial chapters provide a lucid introduction to respiration. It is comprehensive enough for the student and yet bears the author's personal stamp. This makes it somewhat uneven in content, but as the author's interests lie in such fundamental problems as gas exchange and the control of breathing, this in no way reduces its value.

The diagrams are excellent and Dejours uses the O_2—CO_2 diagram intelligently. Students find this diagram difficult to understand and fail to use it to their advantage, and in this book its origins and importance are clearly explained. The legends to some diagrams are over-long and this occasionally makes the text depart too far from the diagram. There is a classical misprint in Fig. 4 where P_{CO_2} appears instead of PO_2 and an equally classical misuse of auscilation for auscultation on page 55. The translation by Dr. Fahri, himself a leading respiratory physiologist, portrays his felicity with both French and physiology.

The lasting impression I gained was that, while this book can be wholeheartedly recommended to 2nd M.B. students, it will serve best those graduates who want to go back to respiratory physiology and see what it was really about. It will be of less value to those studying for M.R.C.P. as it has little clinical bias, but as it deals with the subject in depth it should appeal to all those who wish to get an intelligent grasp of the subject.

T. J. H. CLARK

THE NATURE OF CANCER.

by P. M. Sutton. English University Press. 159 pp. *Price* 15*s*.

A book which gives "a brief account of the cancer problem today" . . . for . . . "the general reader", I cannot find in my heart to recommend as reading for any student.

The text briefly describes normal cells, cell division, and leads on to describe cancer cells and types of cancer. That it is brief and with only 10 line drawings I found a relief; I cannot think that those general readers searching in perpetual frenzy for information would be as pleased.

A book of this nature tends always to fall below student demands and yet can never be adequate for the uninformed. A glossary is included but necessarily leaves much to be explained for the lay reader.

(P. 79) " . . . and since X-rays damage chromosomes it is likely that they cause leukaemia by injuring a special chromosome in the granalocytes, making them cancerous", contrasts with the terrifying (p. 51) "the very word cancer is a description of the crab-like way a malignant tumour grips the surrounding parts" and the sad (p. 91) "poor Hodgkin died abroad a disappointed man, having failed in his life's ambition to become a consultant at Guy's".

There are obvious problems in writing a book of this type. The author has done better than most. However, the question of whether eminent doctors should try to explain in general terms a most specific and necessarily complicated subject to people who are better off not knowing, grows cancer-like in my mind.

W. HUGHES

MENTAL DISORDER AND THE LAW.

by Fleming and Paterson. E. & S. Livingstone Ltd. 49 pp. *Price* 5*s*.

This neat little book, a living proof that medical men and the law can mix, written by a consultant psychiatrist and a barrister, is good. It concisely divides the Mental Health Act of 1959 into nine sections or "chapters", and to those for whom a study of its subject matter is essential, makes work easy. The effect of the division makes the book a triumph in its object—namely coherent understanding of the Act.

Although I have a personal dislike of "Everymans' Back-street Lawyer" or "Icosahedral Symmetry for men on the Streets", this book treads a sure path through a legal mumbo-jumbo minefield to my recommendation.

W. HUGHES

NOTICES

Guy's Hospital Nurses' League

The League Council is anxious to obtain the assistance of a Part-time Secretary, who would be willing to undertake a limited number of hours of work as occasion demanded. It would be essential that this person could attend and take the Minutes at the Council meetings which occur four times a year from 2.30—5.30 p.m. Remuneration in accordance with the usual rates. Replies to: Matron, Guy's Hospital.

Hockey Club

The Past v. Present hockey match, which was instituted last year, was such a success that it has been decided to make it a regular fixture.

It will be at Honor Oak Park on Sunday, March 5th, at 2.45 p.m., and any past players who would like a game are asked to contact David Loader at 8, Burnt Ash Hill, Lee, S.E.12 (KIP 5115), or Surgery (TID 2114).

All spectators will be very welcome and a good afternoon's entertainment is guaranteed.

S. N. CRIPPS,
Fixture Secretary, Hockey Club.

CORRESPONDENCE

Abortion or Abort?

SIR,—The remarks made by R.E.C. on the Medical Termination Bill in *Passim* on 21st January will undoubtedly have pleased members of the Abortion Law Reform Association and those doctors who make a lucrative practice of terminating pregnancy for non-existent medical reasons. Your views, however, have given offence to many compassionate Guy's men and women who, believing in the sanctity of human life, do not support measures which aim to destroy normal unborn foetuses on social grounds, and who do not believe that women should be subjected to a potentially dangerous operation for the sake of removing an inconvenience.

The Royal College of Obstetricians and Gynaecologists, the B.M.A. and the Medical Women's Federation have all published reports to say that while it may be advantageous for the present law to be stated in positive rather than negative terms, there is no need to widen the indications for therapeutic abortion. In particular, they object to Clauses 1c and 1d of the Bill in which it will be legal to terminate pregnancy when "a pregnant woman's capacity as a mother will be severely overstrained by the care of a child or of another child as the case may be" (whatever this happens to mean) or when "the woman became pregnant while under the age of sixteen or as a result of rape." These clauses, they maintain, are tantamount to abortion on demand.

It will be a sad day for "our noble profession" when a Bill is passed which makes it legal for doctors to remove pregnancies for no better reason than that they are unwanted, quite apart from the fact that the operation is never completely free from risk to the mother. Of course, social circumstances should be taken into account, but they must be considered in the light of their impact on the health (mental or physical) of the patient. Mr. David Steel, the Bill's sponsor, has in fact tabled an amendment to be debated in Committee at its next meeting which deals with this point. It states "in determining whether or not there is risk of injury to health or well-being account may be taken of the patient's total environment actual or reasonably foreseeable."

It is, in my opinion, regrettable that in an argument between abortionists and the medical profession, *Passim* should align itself with that of the abortionists.

Yours, etc.,

T. L. T. LEWIS.

Department of Obstetrics and Gynaecology,
Guy's Hospital Medical School.

SIR,—The remarks by R.E.C. in *Passim* of 21.1.67 on this subject cannot be allowed to pass unchallenged.

What does the opinion of one representative of the national press amount to; where "public support is estimated at 80 per cent" for the Medical Termination of Pregnancy Bill? How many of the public, let alone doctors, have read the proposed Bill and amendment and understood the implications, without which an opinion is not of much value? This figure cannot be quoted as a "sure indication of popular demand and social necessity".

The proposed amendment of 21.12.66 will mean in effect that, because of its vague terminology, "abortion on demand" will become acceptable in law. The practical result from this is that the General Practitioner and the Consultant Gynaecologist will be put under great pressure from the patient with an unwanted pregnancy, for whatever reason, to have it terminated. The picture presented by R.E.C., of doctors waiting frustrated for this Bill to become law, I do not believe to be true.

Let it not be forgotten that it is the Consultant Gynaecologist who is usually called upon to carry out termination of pregnancy. It is always an unpleasant, and occasionally a dangerous operation; and this is always glossed over by the protagonists of the Bill. The whole of the training and work of an Obstetrician is directed towards the preservation of the life and well-being of the mother and child. He will not become an abortionist by the passage of a new Bill. Since in the N.H.S. hospitals it is the Consultant Gynaecologists who have to carry out this operation it seems a pity that our opinions have not been obtained directly by those who profess to speak for the profession as a whole.

The crux of the matter is, that whatever Bill may be passed through Parliament on this matter, Gynaecologists will continue to act according to their conscience. In my view, they will not leave the final decision, in any particular termination they are expected to carry out, to anyone else.

Yours, etc.,

A. S. F. BUTCHER

Fairbanks,
30, Amersham Road,
High Wycombe, Bucks.

Cony

SIR,—May I add another story about Cony which was so typical of his kindness?

In 1949 he had arranged to go on a motoring holiday in France with myself and two others. About a fortnight before we were due to leave, he had his coronary. While he was getting into bed in Nuffield, and still in pain, he sent for me urgently. He wrote out a cheque for the expenses of the trip and instructed me that the holiday was to go on without him.

Several months later he told me that he had thought he would probably die that night and, if he had not given me the cheque then, the holiday would have had to be cancelled.

Yours, etc.,

D. R. PUGH

8, Parkmead,
Roehampton, London, S.W.15.

SIR,—Whatever Cony (*super quem pax*) sometimes pretended, he wasn't, even technically, unregenerate. The record of his baptism is here at Philjim, as he always called it. It was of some value to him since he never knew his birthday. His father, a Greats don, omitted to register the birth, and then forgot when it had happened. This obscurity about his origin pleased Cony, and on the strength of the only admissible evidence of his safe delivery, in the church register, he once drew a month's salary and a month's retirement pension simultaneously, to his satisfaction.

Cony's kindness to Chaplains, in the flat above, was unfailing. It extended to their families and their dogs, whom he regaled alike on chocolate and gin.

Yours, etc.,

A. J. M. SAINT

St. Philip and St. James's Vicarage,
Church Walk, Oxford.

SIR,—Do you think you might publish, as part of your memorial to the late Sir John Conybeare, " Coney's Song " from the Residents' Play of about 1929?

Yours, etc.,

STANLEY WHULER.

Hartwell Cottage,
nr. Aylesbury,
Bucks.

Thusly:

I'm a rather lucky dog,
I live in the College,
With a pal along I jog,
Seeking out new knowledge.
When we want to banish care,
We play the gramophoney.
My pal he is called McNair,
And everybody calls me Coney.

The Super yearly has to go
Where Mrs. Eason's bent is.
And I remain her *in loco*
Superintendents.
I play golf at Huntercombe,
Morris is my crony.
In my car there's lots of room,
So come and have a game with Coney.

I have only one small fad,
I just can't stand women.
They attack some helpless lad,
Nice mess they get him in!
I'll keep single for a bit,
Don't like matrimony,
A game of golf, a gin and it,
Are really quite enough for Coney.

Heard about my bloody book
For the young physician?
You should come and have a look,
Buy a first edition.
Jack and Tidy, Price may rave,
Poulton may look stony.
Osler's turning in his grave,
But what the devil's that to Coney?

Efficiency

SIR,—With reference to your article " Twice as Long ", in Passim in the last edition of the *Gazette,* I feel that your praise of efficiency in the Radcliffe Infirmary, as regards average costs per in-patient, numbers treated and length of stay and your corresponding criticism of lack of similar qualities in London teaching hospitals, and Guy's in particular, needs qualifying.

The Radcliffe Infirmary is the parent unit and teaching centre of the United Oxford Hospitals. The latter group includes another General Hospital—The Churchill Hospital—a maternity hospital, a geriatric unit, a T.B. unit, a hospital for fevers and skin diseases. In addition, there is in Oxford the Nuffield Orthopaedic Centre, which deals with the great majority of "cold" cases, and two psychiatric units, which similariy monopolize cases of relevant diseases.

As a result of this selection of hospitals, the Radcliffe deals primarily with acute illnesses and transfers or rejects cases of chronic illness, together with all radiotherapy and most neurological patients. The Radcliffe also houses a busy regional accident centre, which has a rapid turnover of cases, many of which, like head injuries, require only short periods of observation. Although most clinical teaching is conducted at the Radcliffe, some appointments must necessarily be undertaken in the other hospitals mentioned.

The London teaching hospitals, perhaps uniquely, provide comprehensive treatment and care for a variety of patients, and thereby a full range of teaching material. Any comparison with provincial teaching hospitals should perhaps realise differences in environment and services, which make estimations of efficiency more difficult and perhaps valueless.

Yours, etc.,

I. A. BAKER.

Department of Pathology,
The Churchill Hospital,
Headington, Oxford.

[*Our bikini statistics, revealing the interesting but concealing the vital, may have seemed to be just that. However, the very fact that Guy's contains a much larger number of long-stay patients, with accordingly relatively fewer investigations, and still has an " inpatient-week " cost that is higher, is but further indication that efficiency is not on the same level. It would appear that the bikini was very brief indeed, if not transparent.*—EDS.]

Teaching on the Wards

SIR,—May I add a little weight to an important point made in Miss Andrew's letter in the last *Gazette*: " Often more useful information can be obtained from the senior nurses, who when the opportunity of asking is right are only too ready to help and teach." This kind of teaching has always been implicit in the training of Guy's nurses in the wards, and it is encouraging to note that its importance is appreciated by junior student nurses. At the last assessment by the General Nuring Council before I retired, the assessor who had spent her time in the wards, remarked, " The teaching never stops." It is the teaching by the ward sisters and by the nurses to each other that gives the best results, and it is inseparable from the nursing care of the patient.

Yours, etc.,

FLORENCE TAYLOR.

Flat 2,
103, Blackheath Park,
London, S.E.3.

News of Old Guy's Men

SIR,— . . . . If I remember rightly, I did point out that whereas the *Gazette* was primarily a magazine about the hospital and its affairs, I felt that a column ought to have been started concerning the activities of Guy's even elsewhere. It must be remembered that as the years go by, the actual news interest in the *Gazette* gets less and less for those who do not orbit the hospital, but I for one would love to have news of my contemporaries. I have always felt that this would not be an insuperable problem and that areas could be arranged whereby information could be collected say annually and passed on to the *Gazette* office; an example, I could be the area man for the West Midlands, and so on.

Sir, Guy's Hospital and Guy's men are bigger than the *Gazette*. We carry the flag for you the length and breadth of the country, indeed the world, and it's about time you and the hospital recognised us and gave us just a few more lines in your very parochial pamphlet.

Yours, etc.,

P. S. CARTON-KELLY.

The Firs,
St. Margaret's Road, Hereford.

More on More

SIR,—Despite the fact that cynicism and the easy sneer are commodities in liberal supply nowadays, the moral implications of your review of the play, "A Man For All Seasons" ought not to pass without challenge.

Note the contemptuous reference to "More", not to Sir Thomas, far less to St. Thomas More. It is rather surprising that R.N. should thank Heaven that such men are rare.

What, in fact, has "More" done to deserve such treatment? As a devout Roman Catholic, he could not square with his conscience Henry's proposed means of ridding himself of Catherine of Aragon, and of "marrying" Anne Boleyn, thereby betraying the church of which both he and Henry were members. For this he was prepared to suffer the torture of imprisonment in the Tower and execution on Tower Hill. In R.N.'s opinion, this is proof positive that he was "blinded by his own vanity and selfishness, true to himself and no one else." Had "More", of course, been "with it", and had he adopted a practical instead of an absolute morality, he would have taken Cranmer's or even Cromwell's line, both of which R.N. must by implication admire, if he is capable of such a debased emotion.

The fact is that the people of England and of Europe in general never regarded Anne Boleyn as anything but a strumpet.

One cannot help wondering how long the rigid codes of ethics and traditional morality to which doctors and dentists are uniquely obliged by law, to conform, will survive in the hands of perverted moralists who preach "practical morality."

To dismiss "More" as a bore and dangerous is perhaps the most crashing misjudgment since Fanny Brawne's on Keats. Although his undoubted cruelties as Chancellor are in sharp contrast with the views expressed in his Utopia that work was the first attempt to design an ideal society. It has given a word to the language and is still read by cultivated people everywhere.

Yours, etc.,

A. H. STOCKER.

Keats House,
Private Dentists' Wing,
Bush Fair,
Harlow, Essex.

True Liaison

SIR,—I should be grateful if, through the courtesy of your correspondence column, you would extend to me the pleasure of replying to a letter headed "Miss G. Saint", which was recently published in the *Gazette*.

Firstly, may I thank the writer and the many friends who made my work in Salomons Centre so very interesting and rewarding.

During my time at Salomons Centre I was most fortunate in having the opportunity of working with so many gifted people who made me richer and wiser in the knowledge of my field of duty. They include the staffs of Salomons Centre Child Welfare Clinic, Diplock, Caleb and Victoria Wards, Evelina Hospital, the Child Health Department, the Medical School and the School of Nursing and, particularly, those associated with Newcomen House Developmental Assessment Centre. I miss the contact with them and with the students.

My designation in Northumberland is that of Area Nursing Officer, and this appointment involves assisting the County Nursing Officer with the overall administration of health visiting, midwifery and district nursing services. The conditions under which I work are, of course, quite different from those of Salomons Centre and London. Most of the Maternity and Child Welfare Clinics I have seen here, even the so-called old or adapted ones, are well equipped and cheerfully staffed. They are used to capacity by the public of all age groups and the general practitioners. The success of the general practitioners/health visitor/district nurse attachment schemes in Northumberland is largely due to the open-minded, co-operative attitudes and healthy respect of the personnel involved. With foresight, the County Medical Officer and the County Nursing Officer have, for many years fostered and encouraged the principles of real co-operation and good liaison between their staffs, the general practitioners and hospital colleagues. This has obviously been the foundation of the success of the attachment schemes. In addition to general practitioners, hospital consultants from various fields participate in the work of local health authority clinics. Not only is this contact greatly valued by the health visiting staff of the clinics, but, in addition, it ensures the provision of a valuable comprehensive service for the families concerned. It is a pleasure to observe the enthusiasm and appreciation with which in-service training and conferences are welcomed by the organisers and field-worker participants from the three groups of health workers. This is particularly noticeable in the field of mental health.

I would be delighted to give further information about the services in Northumberland and feel sure that anyone wishing to observe for themselves would be more than welcome.

Yours, etc.,

G. SAINT

County Council of Northumberland,
Health Department,
County Hall,
Newcastle-upon-Tyne, 1.

Old Tavern Clock

SIR,—While helping to prepare material for the Gazette History of Guy's in 1947, I was shown an old Tavern Clock in the carpenter's shop of the Works Department. The story as told to me by one of the older members was that his father, who also worked for Guy's had obtained it from his father at the time that Hunt's House was built and that it had come out of an old public house standing on the site, known as the Guy's Arms. This must have been about 1860 and that it had hung in the carpenter's shop ever since.

It was a typical example of the type of tavern clock also known as an "Act of Parliament Clock", because William Pitt's tax of 1797 on clocks and watches led to their being placed in taverns. A similar example used to (and may still) hang in the George Inn. I have, unfortunately, lost my photograph of it, but if you can obtain another one your readers might be interested.

Yours, etc.,

IAN SCOTT

6048, Lockard Avenue,
Mt. Washington,
Cincinnati, 30, Ohio.

NURSING SECTION

The Staff Nurses' Study Week

Study weeks for Junior Staff Nurses have been running for a year and are designed to help the newly-qualified nurses to see their new positions in perspective within the general framework of Guy's Nursing and Administration and the National Health Service.

The work in a community the size of Guy's makes it very easy to confine one's self to the routine ward work, or the work in one's own particular field. It becomes increasingly apparent with experience that the complexities of hospital administration are manifested even at ward level. An introduction to the various levels of Hospital Administration can do much to increase one's awareness of these difficulties.

One of the most valuable aspects of the Study Week is that the staff nurses have an opportunity to talk to and question departmental heads whom they may not otherwise know. The Officers who kindly make themselves available to the staff nurses in this capacity are the Catering Officer, the Work Study Officer, the Medical Records Officer, the Domestic Staff Manager and also the Clerk to the Governors. Interesting talks are also given by the Matron, one or two of the Nurse Tutors, and speakers from branches of the National Health Service outside the Hospital.

The Staff Nurses also have the opportunity of questioning panels. One panel consists of the Supplies Officer, the Chief Pharmacist, the Central Sterile Supplies Department Manager. Another "Brains Trust" consists of an Administrative Sister, a Nurse Tutor, a Departmental Sister and a Ward Sister. Both these panels are ready to answer any questions that may occur to the Staff Nurses.

Groups of Staff Nurses are taken on tours of the Central Kitchens, the Laundry and the Medical Records Departments—places of interest which are usually unknown to the hospital nurse.

The benefits gained from the Study Week are many, and views of the hospital away from the immediate patient care are valuable. Tolerance is also learnt—everybody has their own problems and a sense of proportion is learnt. The Staff Nurses wish to convey their thanks to the Nurse Tutor who is responsible for arranging their Study Week.

The Staff Nurses' Christmas Dinner

The Staff Nurses' Christmas Dinner was held as usual in the Nurses' Home Dining Room. The meal provided by Mr. Kingston was par excellence.

The guest speaker at the dinner was Dr. W. N. Mann, who had some amusing things to say of Guy's in the past, and some interesting comments on Guy's in the present.

Everybody at the dinner voted it an extremely successful occasion.

STAFF CHANGES AND APPOINTMENTS

APPOINTMENTS

Sister R. Sethna (Miller General Hospital, London), to Main Theatres.
S/M G. M. Agbro (Lewisham Hospital), to Victoria Ward.
S/N W. Flower (Royal Prince Alfred Hospital, Sydney), to Cornelius Ward.
S/M A. Phillips (Royal West Sussex Hospital, Chichester), to Victoria Ward.

DEPARTURES

S/N R. Barnish, from John Ward.
S/N J. Rees, from Barnabas Theatre.
S/N E. J. Williams, from Diplock Ward.

SPORT

Few experience the agony of despair and rarely can one be stirred to such depths by the mere pressures of sport, and yet as St. Mary's defeated Guy's in United Hospitals Rugby Cup, remorse seemed widespread. As if religious guilt was avenging for previous rape, so Guy's seemed doomed by their own folly.

Perhaps it was inevitable—a foregoing much improved record, a creditable draw against Plymouth Albion four days before, the betting heavily on Guy's. But the nightmare passed, even the Press somewhat subdued (or were they sadistically consoling), and Guy's revitalised brought continued success against Taunton and also against Davenport Services. In fact their basic play and morale has survived that one game so well that one must suspect a latent, if not delayed, reaction.

Are they completely impervious or simply psychotic?

Guy's, minus an archangel, in fact one might consider a posthumous award, withstood yet another battering as again St. Mary's defeated Guy's in the United Hospitals' Junior Hockey Cup last Wednesday, thus mutilating any means of exoneration.

But fortunately, M. Appleby, along with S. Rear, appeared for U.H. against Cambridge University and helped in a victory of 1—0. S. Rear, an ex-Guy's player, now playing for Teddington, was included in the Middlesex Under-23 Team. A fine performance, marred only by his departure from the Guy's side.

And so we are left with the Soccer XI in February and Rugger 2nd XV on Wednesday to replenish the vast showpiece in the South Common Room.

Even "Charlie" has a gap—but at least from a highly improbable explanation!

SPORTS DIARY

RUGBY FOOTBALL.

Feb. 4.—Coventry. Away.
,, 11.—
,, 18.—London Irish. Home.

HOCKEY.

Feb. 4.—Westminster Bank. Away.
,, 11.—Walton. Home.
,, 18.—Gore Court. Away.

SOCCER.

Feb. 4.—London (U.H.L.). Away.

LADIES' HOCKEY.

Feb. 4.—St. Bart's. Away.
,, 11.—Charing Cross Hospital. Home.
,, 15.—University College. Away.
,, 18.—Royal Holloway College. Away.

CROSS-COUNTRY.

Feb. 4.—U.H. v. Oxford Tortoises, Oxford.
,, 11.—U.H. v. Lancing College, Lancing.

Blues

The Egoist awaits his name in lights, but even his enthusiasm might wane. It is through no delay of the *Gazette* that we print the following from the Blues Committee.

At the last Blues Committee in 1966, the following awards were made for the winter season, 1965—1966. (Our apologies for the delay in printing, but the following have only just been received):

RUGBY FOOTBALL:

C. Thorburn	*Full-Blue*	R. Stansfield	*Half-Blue*
H. C. Sharp	*Full-Blue*	D. R. Elliot	*Half-Blue*
B. J. Rowlands	*Full-Blue*	P. Swift	*Half-Blue*
		D. Hendrick	*Half-Blue*
		C. E. C. Lewis	*Half-Blue*

ASSOCIATION FOOTBALL:

J. Powell-Jackson	*Full-Blue*	I. Nash	*Half-Blue*
		M. Auto	*Half-Blue*
		S. Poole	*Half-Blue*

BOAT CLUB:

P. J. Burton	*Full-Blue*	M. Mace	*Half-Blue*
		J. Pook	*Half-Blue*
		R. Forrest	*Half-Blue*

GOLF CLUB:

B. Bevan-Jones	*Full-Blue*	A. Phillips	*Half-Blue*
		P. Ellis	*Half-Blue*

HOCKEY CLUB:

M. I. Appelby	*Full-Blue*	S. Worthington	*Half-Blue*

BOXING CLUB:

D. Edgar	*Full-Blue*	R. Stansfield	*Half-Blue*
W. Onyeame	*Full-Blue*	J. Crawford	*Half-Blue*

SQUASH CLUB:

J. Newman	*Full-Blue*	J. Topham	*Half-Blue*

HOCKEY

GUY'S v. TULSE HILL 2nd XI

At H.O.P. Saturday, 21st January, 1967
Result: lost 0—1

In a fast, vigorous game, Guy's were beaten 1—0 by a Tulse Hill side which contained three regular county players.

The Guy's defence had to survive almost incessant pressure for the first quarter of an hour; that the score-sheet remained blank at half-time was due to a combination of sterling defensive work, with every member of the defence playing his part, and poor Tulse Hill finishing. With their failure to convert their superiority into goals, the Tulse Hill forwards became less incisive, and Guy's came more into the game

The second half was evenly contested, with play moving quickly from end to end. After ten minutes, Tulse Hill scored when their inside-forward pushed in a shot that had rebounded off a post. Though Guy's came close to equalising several times, with two efforts by McMichem and Brooks standing out, the Tulse Hill defence held out.

On the whole, this was a good performance against such strong opposition. White in goal had one of his best games; Loader was in his best old form, both on and off the field; J. Crafts was as dependable as ever, breaking up many attacks with clever interceptions, while Turfitt played with great spirit after a long absence from the arena. In the forwards, both wings got some good centres across, and Dodd played forcefully in the middle. But all this effort was not quite enough to upset a more skilful and experienced Tulse Hill side.

Guy's: N. White; D. Loader, D. Crafts; N. Turfitt, J. Crafts, C. Pearson; A. Brooks, M. Appleby, N. Dodd, H. McMichem, S. Cripps.

M. APPLEBY

WATER POLO

GUY'S v. Q.E.C.

At U.L.U. Tuesday, 24th January, 1967
Result: won 10—1

Guy's started this game with the advantage of having several substitutes; and after showing ourselves to be the better swimmers in the first half, it seemed that we would make a good score.

In the first quarter Q.E.C. put up some strong resistance, and it was not until the end of the quarter that Guy's scored through Froom. After settling into the game Guy's speeded up the passing, with good forward co-ordination, and goals by Challacombe, Northcott and Froom gave us a comfortable 4—0 lead by half-time.

In the second half Q.E.C. had six men in defence, and only one forward near the Guy's goal. Guy's continued to attack the Q.E.C. goal, keeping the scoring rate high, until towards the end of the third quarter, Q.E.C. passed the ball to their one attacking forward, who put it in the Guy's net with a good shot. After this one bold attempt, Q.E.C. were completely on the defensive, and this gave the Guy's backs a chance to move. Foulds and Forbes, both comparatively poorly marked, were able to move up into the attack, and a solo run by each of them resulted in two more goals.

Goals: A. Froom, 3; G. Northcott, 3; S. Challacombe, 2; D. Foulds, 1; A. Forbes, 1.

Guy's: D. Foulds, A. Froom, S. Challacombe, K. Howard, M. Adkins, D. Davidson, P. Ashford, J. Wood, A. Forbes, G. Northcott, P. Evans, B. Wright.

M. ADKINS

HOSPITAL INFORMATION

APPOINTMENTS VACANT

GUY'S HOSPITAL, S.E.1.

Applications are invited for the post of **Senior Registrar in Paediatrics,** with duties to commence on 1st April, and appointment until 30th September, 1967 in the first instance. Applicants should have a higher qualification and experience in paediatrics. Forms of application are obtainable from the Superintendent, Guy's Hospital, S.E.1, and should be returned not later than **11th February, 1967.**

PASS LISTS

ROYAL COLLEGE OF SURGEONS OF ENGLAND

Final F.R.C.S.

W. Bunting	M. Singh
J. Carruth	T. A. Stoker
K. I. Mackenzie	Carol L. Wengraf
B. J. Main	M. S. Wirk
M. D. Sanders	J. D. Wonham

Final F.D.S.

G. T. Cheney	G. M. Edwards
I. G. Crossman	S. Paramsothy
R. A. Dendy	L. A. Usiskin

UNIVERSITY OF LONDON

M.D.

P. R. Wagner — D. M. MacLaren

Ph.D.

J. W. Osborn

1st M.B.

R. G. Chase

2nd B.D.S.

Patricia J. Benson	W. H. Stephens
G. P. Booth	R. Tudor-Williams
R. K. F. Clark	P. C. Williams
R. W. Jones	N. R. Winter
R. P. A. Lovell	P. R. Wright
C. G. Neville	

UNIVERSITY OF OXFORD

2nd B.M. (Final)

C. J. Davies — R. J. Morgan

UNIVERSITY OF CAMBRIDGE

Final M.B.

Part 1. Pathology and Pharmacology

K. G. E. Brown	R. A. C. Hughes
E. P. Davis	A. B. Loach
P. D. M. Ellis	B. W. R. Moore
M. G. Falcon	J. H. Newman
M. J. B. Farebrother	D. J. Peters
H. Garmany	J. G. Pickering
J. J. Halliday	D. E. P. Shapland
B. D. W. Harrison	N. M. White

ROYAL COLLEGE OF OBSTETRICIANS AND GYNAECOLOGISTS

M.R.C.O.G.

A. Aribarg	J. Lambourne
E. E. Cockayne	L. C. Nash
F. S. Davidson	J. E. A. Oni-Orisan
C. N. Garstang	B. L. Robinson
	P. R. Wagner

COLLEGE OF PATHOLOGISTS

Final Examination

A. E. Green

CONJOINT BOARD

D.M.R.D.

T. Sherwood	F. Warwick

D.P.M.

Mary Restell	P. J. A. Willems

D.A.

C. E. Briscoe	W. A. Norman
P. G. C. Calverley	Julia A. S. Rice

PERSONAL

NEWPORT, PEMBROKESHIRE. Beach side holiday house, fully furnished. April—October lettings. Ideal for family or group. Telephone: ROD 9675 after 6 p.m.

SIXTH PARTNER REQUIRED after preliminary assistantship, in Stamford, Lincolnshire. Senior partner retiring October 31st, 1967. Four of the partners are old Guy's men. Applicant must be British, male, under 35 years and eligible for obstetric list. He will be offered six months assistantship to commence May 1st at a salary of £2,500 before becoming a partner on November 1st with parity at the end of four years. House or flat will be available. Excellent schools in the town to which the partners are medical officers. Access to pathology and X-ray departments at Stamford hospital. Equal rota for night work and weekends. Six weeks holiday p.a. Central surgery only; no dispensing—Dr. Till and partners, 24, St. Mary's Street, Stamford.

CHANGES OF ADDRESS

Dr. and Mrs. M. A. McL. Bailey, Little Horsepools, Edge, Stroud, Glos.

Mr. and Mrs. E. O. James, "Fairways", 22, Ar-y-Bryn, Pembrey, Burry Port. Carms. Telephone: Burry Port 274.

BIRTH

TOMBLESON—Little Ash, Ditchling, Sussex. To Philip and Pauline, a daughter, Emma Jane, born New Year's Eve.

JAMES—On January 1st, 1967, to Catherine (née Fischer) and Edward O. James, L.D.S., R.C.S.(Eng.), of Llanelli, a daughter, sister for Caroline.

We would like to remind our readers that all copy for inclusion in the Gazette must be received eight days before the publication date.

Birth, Marriage, Death and Change of Address notices are without charge to subscribers. For Personal notices the charge is £1 1s. 0d. for 15 words, additional five words 10s. 6d. minimum 15 words. Non-subscribers will pay £1 1s. 0d. for all notices other than Personal

GUY'S HOSPITAL GAZETTE

EDITORS D. S. ROBINS and C. B. BROWN
SPORTS CORRESPONDENT J. G. PAYNE
NURSING CORRESPONDENT E. A. MALPAS

FORTNIGHTLY TWO SHILLINGS VOLUME 81 NUMBER 2050

PASSIM

Obesity or Not?

With co-ordination that smacks of a medical press overlord, the medical magazines recently devoted themselves to Obesity. The figures were expectedly startling, one series giving figures for childhood obesity in Britain as 40 per cent through to 31 per cent with middle life obesity, while the Food Education Society claim 50 per cent as a general national figure—a "more cautious estimate". Whatever their standards of average weight, series such as these merely impart a cold, statistical vapour to an easily observable feature of our society. *Circumspicere!*

A summary can be as impressive as it is short. The average annual food consumption of the average American male with his "wife and two kids" (at last they have abandoned that preposterous extra quarter-child), when presented photographically has the touch of Cecil B. de Mille directing a still from a Hammer Films production. Fifty-five tons, including that extra 240 lbs. a time, in a forty-year adult period are cajoled or prodded by an otherwise reluctant tongue past the benevolent constrictors to be dealt with by the insatiable abdominal serpent that is the gift to Mr. Average U.K.

The appalling list of diseases associated with obesity is equally horrific, and we all know what happens to our fat, fair, fifty-ish female friends and relations. With transatlantic glee one interested party tells us that treatment of obesity *per se* costs the N.H.S. £2¼ millions p.a. and 600,000 hours of doctors' time. In a reverse direction a French physiologist has been a party to aiding and abetting a number of Gallics with subconscious Münchausen Syndromes in their efforts to become eligible for the Parisian "100 Kilo Club". His only complaint was the difficulty in getting them beyond 98 Kg. The medical profession has long found obesity an Elysium for prescribing pet and patent panaceas. They vary from an awe-inspiring Italian administration of chorionic gonadotrophin to our local Great Maze Pond six oranges, a lettuce and a pinta milka day. Most are careful to undertake an infinite variety of experiments and investigations to give some scientific backing to their claims. There is, however, something vaguely sinister when one such investigator spends hours analysing 30,000 frames of a ciné film depicting overweight girls playing tennis.

That it is a question of appetite there is little doubt. But as to the nature of the appetite? Abyssinian and Oceanic maidens fattened for the marriage market until they are often unable to walk is a generalized form whose localized varieties extend from Miss U.S.A.'s bust to the Bushwoman's steatopygia. Smoking is claimed to decrease hunger, yet while we all know by now that it's the tobacco that counts we are told by at least one author that calories don't. With this muddle it is not surprising that the British have retreated into their age-old solution and are in the process of forming a British Obesity Association.

This is all such fun. The problems, the morbidity, the economic sacrifice, the social embarrassment and the widespread disregard for the appeals of Oxfam in a world with two-thirds of its population malnourished—all these bells simply cannot be tolling for us, can they?

Where the Future?

Evolution, we are told, is the natural selection of those organisms that are best adapted to live and procreate in a particular environment.

The anthropologists have, in the past, mainly concerned themselves with tracing the structural changes that have occurred over the millenia. But in the last 100,000 years Man's evolution has become more a cultural one within the increasing complexity of his societies. This comparatively rapid development has been very much associated with increased cerebral activity.

There is no doubt that today a man's intellectual ability ranks as one of his most important assets. Intelligence gains respect, courtship and even envy. Sir Julian Huxley, the father of Humanism, has suggested that the breeding of University types might produce a superior intelligentsia. That is, the obstetrician and paediatrician in partnership should best direct themselves to supervising reproduction of improved qualities, as is standard practice with animal breeders.

In fact, Professor Heyns, of South Africa, has devised a machine for abdominal decompression for use during the last trimester and the first stage of labour of pregnant women so as to prevent hypoxia and therefore neuronal damage in the foetus. This process has apparently produced better performers, and, as it is hoped, more intelligent individuals. For it is proposed that when the quality of the persona as a biological unit is improved, the State must surely recognise this as its main asset.

However, eugenicists say that reproduction of *homo* on the basis of natural selection has been a dismal failure. When a high degree of cerebral development appears, it does not continue to rise as would be expected. It reverts, as it is expressed, to the mean or mediocre. One is therefore driven to suspect the environment of the zygote for being responsible for this decline, rather than the zygote itself. It is not to say that the genetic influence fails, for it is commonplace that the highly gifted child is born almost exclusively to parents who are richly privileged and endowed. Even this selection does not raise the general standard appreciably, for so many mediocrities fill the ranks where the elite might be expected.

With the advent of this new device and its promise of improving the environment of the foetus during those periods of risk, we seem to be on that new frontier which Huxley valued, the production of a superior intelligentsia.

It is within man's power to improve his intelligence, but as Lichtenberg wrote in 1799, "Honest, unaffected distrust of the powers of man is the surest sign of intelligence."

We congratulate Mr. Guy Blackburn on his appointment as "Honorary Consultant Surgeon to the Army at home".

We also offer our congratulations to Dr. Robert Knight on his appointment as Clinical Tutor at Guy's as from February 1st.

GUY'S DIARY

FEBRUARY			EXHIBITION IN The Gordon Museum—BURNS.
20th	M.	1.00	Clinical Lecture. Dr. McARTHUR.
		8.00	Opening Night: RESIDENTS' PLAY.
21st	Tu	1.00	Clinical Lecture. Dr. MOYNAHAN.
		5.00	Medical Genetics Series: In the Anatomy Theatre. Dr. J. FRASER-ROBERTS: "Multifactorial Inheritance in Man."
23rd	Th.	1.00	Clinical Lecture. Mr. GLOVER.
25th	Sat.	10.00	Clinico-Pathological Meeting: In the Clinical Theatre.
27th	M	1.00	Clinical Lecture. Professor F. KERDEL-VEGAS, Professor of Dermatology, Central University, Venezuela: "Virus Infections involving the Skin.."
		7.30	Opening Night: "TEN LITTLE NIGGERS". Guy's Hospital Theatre Club.
28th	Tu	1.00	Clinical Lecture. Professor ATKINS. "Duodenal Ulcer and Its Consequences."
		5.00	Medical Genetics Series: In the Anatomy Theatre. Dr. J. M. H. Campbell: "Common Congenital Defects, I."
MARCH			
2nd	Th.	1.00	Clinical Lecture. Professor HUNT. "Tests of Genetic Function."
3rd	F	1.00	Clinical Lecture. Dr. FORMAN. Film: "Scabies".

ANNUAL CLINICAL DENTAL MEETING, 4th MARCH, 1967

ANATOMY LECTURE THEATRE, MEDICAL SCHOOL.

11.45 a.m. Lecture: *Fluoride-containing Toothpastes; a three-year clinical assessment* - Dr. M. N. Naylor.

THEATRES Nos. 3 and 4 (FIRST FLOOR, NEW GUY'S HOUSE).

Operations commencing at **10.0 a.m.**

There will be DEMONSTRATIONS AND DISPLAYS in all the Departments of the School. Some members of the Visiting Dental Staff will show clinical cases on the second floor, Dental Department.

DENTAL LECTURE THEATRE.

2.30 p.m. Lecture: Cases You Have Sent - Professor R. A. Cawson.

There will be DEMONSTRATIONS AND DISPLAYS in all the departments of the School.

TEA will be served in the Cafeteria, East Wing, Guy's House, at 3.30 p.m.

Programmes giving full details will be available at the Clinical Meeting.

GEOFFREY STEWARD RAWSON, M.B., B.S., M.R.C.S., L.R.C.P., D.P.M.

Geoff Rawson, who was Assistant Psychiatrist on the staff of St. Augustine's Hospital, Chartham, died suddenly on Christmas Day. He was forty-four.

Geoff was born and brought up in Bury and embodied all the warm qualities that are found in people from Lancashire. He was a talented games player, captaining his school cricket eleven and later playing with success in the Lancashire League. At the outbreak of the war he joined the Merchant Navy and served for three years until he was discharged on medical grounds. The significance of the early manifestations of his cruel illness, as they gradually emerged, eluded his doctors for a long time and he patiently bore the fruitless attempts at psychiatric treatment. Later, the true diagnosis of ankylosing spondylitis was made, when he came under the care of a physician at King's College Hospital, whose kindness and interest made a deep impression on him. He then decided, and was encouraged, to take up medicine. Entering Guy's as a student in 1946 he suffered many long setbacks through ill health but with a determination and courage for which all who knew him had the utmost admiration he qualified in 1954. He was awarded the Begley Prize by the Royal College of Surgeons and although proud of this distinction he was characteristically amused by its irony, since he knew he would never do any surgery.

He then spent six months as Assistant House Physician followed by another six as House Physician at Guy's, before becoming House Physician to the York Clinic. After this he enlarged his experience in general medicine as Senior House Officer at New Cross Hospital before finally embarking on the career in psychiatry to which his earlier personal experiences had strongly attracted him and for which, with his kind, generous character, he was ideally suited. He became Registrar then Senior Registrar at Belmont Hospital, taking his D.P.M. and was appointed Assistant Psychiatrist at St. Augustine's Hospital in 1962.

Geoff's many extraordinary qualities endeared him to all who met him. He had a rather diffident manner, but his conversation and writing sparkled with humour and contained an unusually vivid vocabulary. In spite of his severe physical disabilities he played squash and tennis skilfully and occasionally played a cunning game of cricket. Relatively late in life, with furious application, he took up golf—a game often beyond the competence of those in normal health—and within eighteen months was playing to a handicap of three. This tenacity and enthusiasm pervaded his work at which he was greatly gifted and highly successful. A senior physician who knew him well and looked after him in his last years, said of him that "he had a touch of genius" but his very success and energy made him incapable of sparing himself at the expense of his patients. Ultimately the force with which he drove himself and the indirect effects of his long illness robbed him of his life at a tragically early age.

All who knew Geoff will remember this brave man with great affection and will wish to offer his widow, Isobel, and their two children deep and most sincere sympathy.

R.K.K.

Dr. Geoffrey Rawson was an outstanding student, and an outstanding House Physician; it was in the latter capacity that I came to know him well. He chose, partly on Cony's advice, and partly on mine after his appointment with us in this Department, to specialise in psychiatry. He had virtually every qualification which such a course of action most requires: that is to say he was a first-class doctor, a man who took crises in his stride, but never brushed them or the people involved in them on one side, and was particularly noted by the patients for his kindness and imagination, and by all the staff for his tremendous clinical acumen, resource and flexibility. It was the same with his leisure: many men, progressively crippled by ankylosing spondylitis, would have recognised themselves as debarred from sport as a form of recreation. Geoff Rawson took up golf and steadily

progressed to a single figure handicap. The last time we talked together was some time after he had left Guy's and in the course of one of Cony's memorable dinner parties. I asked him how he had managed this phenomenal achievement as a golfer. His reply was characteristic, in that candour to a friend, humour in what would otherwise have seemed a tragic setting, and a completely sensible reply to what might otherwise have seemed an impertinent question, were combined.

> "Well, you see, since I can't move me head without twisting me whole body it's easier for me than for most people to keep my eye on the ball, and to keep it there after I've made the stroke and until the ball's well on its way. . . ."

In fact, I knew the question wasn't impertinent, because after all we were friends. He will always be remembered as a friend to be proud of.

D.S.-C.

The tragic death of Geoffrey Rawson, at the age of 41, was briefly reported in the last issue of the *Gazette*.

My own acquaintance with Geoffrey was relatively short, just a few years out of the period 1946 to 1954, during which we were fellow inmates of Sophie's hostel.

At the conclusion of this time he gained the distinction of being awarded the Begley prize by the Royal College of Surgeons and embarked upon his post-graduate training which included six months as house-physician to Drs. Hampson and Kauntze and then a year as a house-officer in the psychiatric department, York Clinic.

At the time of his death he was a Consultant Psychiatrist to St. Augustine's Hospital, Chartham, near Canterbury.

Throughout most, if not all, of his undergraduate days, Geoff was greatly afflicted with ankylosing spondylitis, but he bore the pain and discomfort with such quiet courage and determination that many of his colleagues knew nothing of his illness.

The resulting distillate of his essential character and ill-health produced a man of considerable humanity and none of those who were privileged to be his friends can fail to recall with warmth, his kindness, humour and wisdom.

We mourn the death of a friend who was a powerful influence by his example for fortitude, and extend our deepest sympathies to his wife, Isobel, and children.

NOTICES

Guy's Hospital Society: South Wales and Monmouthshire Branch

The above Society will be holding their Annual Dinner at the Park Hotel, Cardiff, at 7 for 7.30 p.m., on Saturday, March 11th, 1967. Tickets 35/-, plus 10/- Membership Fee to Society. The Chief Guest will be the Rt. Hon. Lord Brock, and it is hoped members will make every effort to attend. Those who do not receive notices, please forgive and apply to the Secretary, G. Morwent-Brown, 4, Plymouth Road, Penarth, Glam., with remittances. This meeting coincides with the Wales v. Ireland Match at the Cardiff Arms Park. Members meet there in the Lounge for tea after the match.

Boxing Club Dinner

Guy's Boxing Club are having their annual Past and Present Dinner in the Old Miller of Mansfield on Friday, March 31st. All ex-boxers are cordially invited and should write for further details to the Boxing Club Secretary—Sam Marsh, East Wing, Guy's.

THE NEED FOR A SOCIAL WORK SERVICE IN HOSPITAL TODAY

A SOCIAL WORKER'S VIEW

By Diana Hunter, A.I.M.S.W.

Head of the Department of Medical Social Work

The recent death of Miss Addiscott who was the Almoner at Guy's from 1927 to 1952, will have brought back many memories to those who knew her. It may also have started people thinking about the apparent difference between Social Service then and now. For those not primarily concerned with social work practice it is difficult to keep abreast of present-day trends and methods of help and to understand their place within the Welfare State. The continuing development of the Local Authority Services, with their emphasis on "Community Care", together with the increasing statutory provisions of the Welfare State, have radically altered the need to provide social work help in the hospital. Added to this is the general shortage of trained Social Workers, and one finds oneself faced with the questions —should the hospital still be concerned with the social problems of its patients?—is there really still a need for this service in hospital today?

As a Social Worker I believe the answer to both questions is yes—but that the time has come to review the services offered and to try to define what are the present-day social problems of patients in hospital, and how, and by whom, help can best be given. With this need in mind I recently approached the Medical Committee for help and advice on the reshaping of the services at Guy's. It has been suggested to me that this might also be a good moment to write about the social needs of patients today.

Miss Addiscott wrote in 1923:—

"The social conscience is gradually awakening to the fact that to help a fellow creature is the most difficult and responsible task that a human being can undertake, and with this awakening has come the recognition of the necessity for highly specialised training for Social Work."

How right and far seeing of Miss Addiscott. This was proved by the Younghusband Report* in 1959. This report stressed the need for more trained workers of varying grades and resulted in the establishment of Special Courses for Training in Social Work. The hospital

*Report on the Working Party on Social Workers in the Local Authority Health and Welfare Services.

Worker, both Psychiatric and Medical, with her experience and understanding in helping sick people, was called upon to play an important part in the training of these workers. The Department at Guy's has been concerned with this since 1964 when a Student Unit was established.

These newly trained Workers have mostly been absorbed by the Health and Welfare Services as part of their general policy of expansion. Recently they have been joined by an increasing number of Medical and Psychiatric Social Workers, who are finding there, better salaries and more opportunity for using their skill. This drain from the hospital service is already affecting its ability to give social help to patients in hospital. Is this perhaps an indication that the day of the Social Worker in hospital is numbered? With all the provisions for help within the community what is left for the hospital to do?

Before 1948, this was not a difficult question to answer. There were practically no Welfare Services to call upon although Voluntary Associations gave limited help. Many people became ill or failed to respond to treatment, because of the lack of the basic needs of survival —food, clothing and shelter. The success of medical care often rested on the provision of these and the role of the Social Worker, or Almoner as she was then called, was clear to all.

Today the situation is very different, yet illness, in spite of all the provisions of the Welfare State, still brings many anxieties and personal problems for both patients and relatives. Where these impinge on the patient's ability to accept or profit from medical care— then surely they *are* the concern of the hospital?

In a Society which boasts "full employment" and of being "affluent" there is often little room for those who, because of illness or age, cannot make the grade, and the Welfare State can be a poor substitute for the friendly help of neighbour, relative or friend.

The first impact of illness and all it involves often occurs at hospital as a result of sudden illness, accident or at the time of diagnosis. At this stage the selective use of the Medical Social Worker can be helpful. While many doctors and nurses are fully aware of the social implications of illness, they often do not realise that in the Medical Social Worker they have available someone specially trained to give help to sick people. By her use at an early stage the patient or relative can be relieved of much anxiety while the anticipation of possible difficulties can often prevent their development and ensure that they did not hinder the patient's future care.

The Social Worker knows that certain people, because of their personality, age or diagnosis are "socially at risk". Among these I would specially mention the following:—

1. Old people—with particular regard to those living alone or with relatives.
2. Patients with terminal illness for whom no further hospital treatment is recommended.
3. Patients admitted following sudden illness or accident which is likely to lead to some disablement.

4. Patients with chronic illness, and those facing prolonged treatment or inactivity, especially the young adult.
5. Relatives—many of whom are asked to carry a heavy burden caring for a sick person at home, and who, however willing, often need help and advice in doing so.

Many patients admitted to hospital, even from among those "at risk", will be perfectly able to manage without the help of the Social Worker. It is essential, however, if the hospital has a Social Work Service—that it is made available to those who need it, and that it is used freely for the benefit of both the patient and relative. At present the referring of patients for Social Care is very much a hit and miss arrangement which often results in no referral at all or in one being made so late that very little can be done to help. It seems that there is an urgent need to give thought as to how the Service is used, by whom referrals should be made, and at what stage in a patient's treatment.

One method which is being tried out at the moment is that of a weekly ward discussion—often at the end of the Consultant's ward round—when decisions can be taken on the advisability of social help for the patients. This seems to save considerable time and ensure that everyone knows what is arranged. Perhaps this method of consultation could be extended.

Summary

In spite of the development of the Welfare State and of Community Services, I, as a Social Worker, still see the need for the hospital to give a Social Work Service to patients but with more emphasis on prevention and on helping patients and relatives with their personal anxieties which often make it difficult for them to take full advantage of medical treatment and after care. I believe that the demand for such a service is limited and that in future fewer Medical Social Workers will be required in hospital. The care of patients leaving hospital is well catered for by the Local Authority Services, and we can safely leave this to them, provided the hospital recognises its responsibility to see that both patient and Local Authority understand the position and the nature of the help required. Here the use of a Welfare Assistant within the Department of Social Work, with a detailed knowledge of the Services available can be useful. She can also help with many of the practical requests for help received such as arranging convalescence, etc.

This liaison between Hospital and Local Authority is vital and in the area of Social Care it should be the hospital Social Worker who has this responsibility. She in her turn depends on the awareness and interest of the Medical and Nursing Staff in recognising a need and asking for this help for their patients.

This is a Social Worker's view of the need for Social Work help in hospital—what are those of the doctor and nurse? It would be very interesting to know!

VOLUNTARY HELP AT GUY'S

By Sister A. L. Amsden
Assistant Matron

Voluntary help at Guy's has until now come mainly from the Ladies' Association, the Red Cross Library Service, and the Bank of England St. Christopher's Fund. This help is greatly appreciated by staff and patients, and early in July last year Matron requested the Board of Governors to consider whether an expanded scheme for organised voluntary help, which could provide a wider variety of useful services to the Hospital might be planned and implemented.

The Chairman requested information concerning existing schemes, and several visits were consequently made to two teaching hospitals in the London area. One scheme had been operating successfully for two years, the other was in the early stages. The visits yielded valuable information for it was possible to get the "feel" of such services, and to talk with the volunteers themselves, as well as with professional staff in the working areas. Additional information was gained at the Kind Edward VII Fund for London which (in response to the growing national interest in organised voluntary help) held a day conference during the summer. Two representatives from Guy's attended and heard speakers describe enthusiastically both public and private voluntary help schemes. It appears that in these days of ever-increasing leisure time, the average citizen is seeking an outlet for his energies which would prove both useful and rewarding; there is also a great desire to help other people. Unofficial bodies are spontaneously emerging—for example, neighbourhood groups—in addition to well-known voluntary associations, and speakers therefore felt that hospitals could with advantage tap this vast source of goodwill and practical help.

In America, of course, practical voluntary help has for some time been a fully recognised part of hospital life but, as in other ways, the Briton differs from the American in that he likes to be invited to give his help and, as British hospitals have never actively encouraged citizens to give practical help in the hospitals, voluntary help schemes of this type are comparatively rare. In 1962, however, the Ministry of Health indicated the need for voluntary help in a memorandum (HM (62) 29) which urged hospitals and local authorities to expand the voluntary helpers' programme.

The secret of success in *all* services is in good organization, and with a voluntary help scheme this is of vital importance. Those receiving help must be as enthusiastic to have it as the volunteer is to give it. Although this desirable situation might well be taken for granted, it has been shown by experience that in order to ensure such a state of affairs exists and is constantly maintained, there should be

at the helm a vital personality with considerable understanding and organizing ability. It is this person's responsibility to select, organize and administer the volunteer. The appointment of a full-time voluntary help organizer was therefore strongly recommended.

The favourable impression gained from the hospitals with voluntary help, and the success of organized schemes as described by the speakers at the day conference, supported strongly the recommendation made to the Chairman that Guy's should have a Voluntary Help Service.

The Governors having considered the finding of the investigation were pleased to accept the recommendation and to approve the appointment of a salaried organizer. There was an enthusiastic response to the advertisement, and recently Mrs. Marie McGlone has been appointed as the Volunteer Organizer.

During the next two or three months Mrs. McGlone will be visiting all heads of departments, the Ladies' Association, the Guild of Ex-Patients, members of staff, and union officials, discussing and selecting those jobs which are suitable for volunteers. Later, she will embark on the task of interviewing and selecting volunteers and allocating them to the right job in the right environment. In this connection, voluntary work must satisfy, by being worthwhile and demanding. There is nothing more dispiriting to the volunteer than to find that there is nothing useful for him to do. Hospital staff, too, need to be educated in the use of volunteers and to appreciate the rôle which they can play in the daily routines of the Hospital. One might think that all these facets of the situation are obvious, but no one who has used voluntary help or given it, would be deceived by the apparent simplicity of the task. If the volunteer is to be used to advantage—and enjoy himself—such aspects as temperaments, potentials, home commitments, hobbies, and evening classes, must be given careful consideration.

How Are Volunteers Recruited?

Up to the present, hospitals already running voluntary help schemes have been embarrassed by having too many spontaneous offers of help from suitable candidates. This happy state, however, may not always exist and other sources will have to be found. In such a case, business houses, the local authority, and religious bodies are likely to prove most co-operative. National voluntary bodies, for example the Red Cross, will also be advised as will the churches and schools in the vicinity of Guy's.

It has been the experience of other hospitals that groups of the older pupils from local schools are eager to help in hospitals. There are a variety of jobs which these students can do, such as sorting second-hand clothing, manning information desks, making up scrap books and helping in the libraries, etc. Pupils are not as a rule allowed in the wards but there are many other spheres of activity offering valuable opportunities to those who may be interested in taking up hospital work as a career. From another point of view the hospital, in offering these opportunities, is broadly contributing to the teaching of good citizenship.

What Can the Volunteer Helper Do?

First, it should be clearly understood that the volunteer is not a substitute for paid labour, but is complementary to it; secondly, he must be given worthwhile work so as not to become merely a drudge at everyone's beck and call; thirdly, he must be integrated into the Guy's setting and properly instructed. The object being to make him feel an indispensable member of the hospital team, and the helped wonder how they managed before the volunteer became an integral part of hospital life.

The jobs available to the volunteer are many and varied. A number of voluntary workers will come in the evenings, the time when help is particularly welcome, since clerks, receptionists, orderlies and typists usually finish at 5.30 p.m. Other jobs include ambulance escort duties, reading to or writing for patients, helping with the meals, hairdressing, making beds, hospital guides for visitors, and trolley shops—there is really no limit to the potiential use of the volunteer. One has only to pause when there is a job to be done and decide whether, with proper instruction, it could not be done satisfactorily by a volunteer—always provided the job is not one which can be done by an employee of the hospital.

For a period of time after a volunteer has been allocated, regular visits have to be paid to him and his "employer" to ensure that both are satisfied; once established, an occasional meeting between the volunteer and the organizer is usually all that is necessary.

How Many Volunteers Are We Likely To Have?

To begin with the build-up will be slow. Until the outline of a service emerges and the few have got into their stride, a great deal of the Organizer's time is spent in supervising the volunteers and in making sure that the helped and the helper are satisfied. In the time that is left to her, Mrs. McGlone will be identifying and specifying tasks for the next contingent of volunteers. Interviewing, careful selection and placing are the next steps, and so this slow process of building up an effective team will repeat itself until the requirement for volunteers is satisfied. After this, it is just a question of replacement and/or expansion where necessary. One hospital recruited 120 volunteers over the period of a year. (It may be of interest here to note that during the past six months Guy's has received a number of letters from people offering help to the hospital in various capacities.) The management and deployment of such a large body of people requires the services of office staff but, again, the Organizer can staff her office with volunteers.

Experienced volunteers can teach new recruits. One hospital gathered a team of selected volunteers who were given a series of lectures by the nurse tutorial staff, thus enabling them to help the Organizer in teaching and supervising. Once the service is running smoothly the turnover in personnel can be satisfactorily absorbed ; small groups of volunteers suitable for specialised instruction will normally emerge and so with careful management the service can regenerate itself.

Will He Be Dependable?

This is an important consideration. It may fairly be said that the right volunteer in the right job will be an unqualified success, and the worst of British weather and railways will not deter him. This has been the happy experience of other hospitals.

* * * *

The advantages, it seems, engendered by a voluntary help scheme outweigh the problems connected with its organization and integration and, all things considered, its inception and maintenance can only benefit the Hospital. This is its purpose, an aim which with co-operation can surely be achieved. Volunteers, too, can have a very refreshing influence on institutional life. This is partly due to their unconcern with the wear and tear of hospital routine, and partly because they bring with them the atmosphere of the world outside.

Apart from the practical aspects there are wider implications to hospital based voluntary help schemes. The voluntary helper in our midst helps to demonstrate the fact that the hospital is part of the community, and glad to accept help from it. At the same time, the community is offered the opportunity of learning something of the realities of hospital life which in the long run can contribute much to better understanding.

CORRESPONDENCE

Tower Block Development—Preliminary Site Works

SIR,—In my earlier letter about dismantling the Memorial Arch, which appeared in the *Gazette* in January this year, I promised to give you the sequence of further work which is about to be carried out to clear the car park site to the north of New Guy's House and prepare it for the next stage of major rebuilding.

A main sewer running across this site will be re-routed, together with electricity, gas and telephone cables, along Great Maze Pond from Sparricks Row to St. Thomas' Street, and this in turn involves the replacement of sewers and services under the Hunt's House subway.

The effect will be to put the section of subway from the Hunt's House staircase to Guy's House staircase out of action while the work is going on. The opportunity is also being taken of widening this section of subway and its approaches so that, in future, it may be used for goods traffic such as the linen train. This is in line with the policy of keeping internal goods delivery services underground and, indeed, in the longer term, of keeping outside delivery vehicles to the periphery of the site so that the surface will be used only by pedestrians, ambulances, and Hospital Service cars.

The work on the subway will mean opening it so that in effect there will be a wide deep trench along the road in the Park immediately next to Hunt's House. A temporary plank roadway and footpath will be laid on the pavement and grass

so that the way to Hunt's House and Nuffield House for ambulances and essential vehicles may be kept open, and there will also be a number of pedestrian bridges across the trench, for example at Smith's bookshop. The front entrance to Hunt's House will not be affected and access to the New Guy's House subway from Hunt's House staircase and lifts and from the Nuffield House end of the subway will also be maintained.

As the work progresses, Zetland House and the College will be demolished as they occupy an area that will be used during the Tower Block construction, and an ambulance hardstanding will be built near the entrance to Back Surgery.

All this work is clearly going to be felt in the day to day affairs of the Hospital, and the overriding need to ensure access to the park at all times has made careful phasing necessary. As the work proceeds the main entrance route into the Hospital will be affected. For example, when Great Maze Pond is closed while services are re-routed, the Hospital's "front door" for vehicles will be changed to Snowsfields. Notice will be given of these changes, and new routes will be kept signposted. Although noise, dust and other unavoidable hazards will be kept to an absolute minimum, everyone's tolerance is sought during what must inevitably be a time of upheaval.

A section of the notice board in the Colonnade will be available for news bulletins as work progresses, but your readers may find it helpful to know the following main dates in the programme:-

1.	Lay temporary road and lay-bys in the park.	13th February, 1967
2.	Close Hunt's House tunnel, and later excavate north of intersection with New Guy's House tunnel from	20th February, 1967, to mid-February, 1968.
3.	Reduced width of road between Smith's bookshop and the Colonnade steps while services re-layed, between	20th February, 1967, and 6th May, 1967.
4	Work on provision of ambulance hardstanding, north-west corner of New Guy's House	27th February, 1967, to 9th June, 1967.
5.	Close Great Maze Pond from Memorial Arch to St. Thomas' Street while services are re-layed.	19th June, 1967, to beginning of November, 1967.
6.	Demolish College.	July, 1967.

Yours, etc.,

A. H. BURFOOT
(*Clerk to the Governors*)

G.P. Building Programme

SIR,—May I be allowed to comment on the interesting paper by Mr. Lester which you published in the Guy's *Gazette* for the 21st January. Mr. Lester rather understated the work the West Riding County Health Department is undertaking under the direction of Dr. R. W. Elliott the County Medical Officer.

In 1963 after negotiations with the Local Medical Committee and the local Executive Council the County Council adopted a vigorous policy of furthering co-operation between its own staff and the 1,450 general practitioners with patients in the administrative county. The policy now has four facets:

(a) The provision of premises for joint use by family doctors and the local health authority staff. They are being provided not only by the use of existing clinics, but also by the provision of health centres under section 21 of the National Health Service Act, 1946. At the present time there are about 68 family doctors practising for either main or branch surgery purposes from our premises. By the end of 1968 we hope that some 200 family doctors will be working from our premises, most of them from purpose built section 21 health centres.

(b) The attachment of health visiting and nursing staff to practices of family doctors. At present 140 health visitors, 70 district nurses and 45 midwives have been attached to practices.

(c) The publication of quaterly bulletin for general practitioners, to improve communication between the two sides of the service.

(d) The handling of local health authority immunisation records and those co-operating general practitioners on the West Riding Computer. A pilot scheme has begun recently in two areas.

General practices and the community health services are in a stage of rapid transition: it is important that co-operation should be encouraged by all available means and not only by the provision of health centres.

May I make two further points.

First, I feel that placing the date of the application of new methods of preventive medicine after 1975 is to leave the matter far too late. The consequence of the measure of success we have had in co-operating with general practitioners in the Riding is that we must consider immediately the content of the clinical work being undertaken by our medical officers.

Second, one is not happy about Mr. Lester's statement that the increase in mobility will enable general practitioners to practise in larger and larger groups. A considerable proportion of the population still live in isolated rural communities where communications are not easy and while his view may well be true for urban areas it is certainly not true in the Yorkshire Dales. In addition to this the greatest health needs occur, and are always likely to occur, in people who because of illness or because of lack of means are the least mobile. There must, therefore, be an optimum size in each area for groups of practitioners, depending at least on the population structure and density, the ease of local communications, the local economic circumstances and the local prevalence of disease and disablity.

Might I again say how delighted one is to see a stimulating article such as this in the Guy's *Gazette;* I hope Mr. Lester will continue his work and its discussion.

Yours, etc.,

H.W.S. FRANCES
Deputy County Medical Officer

County Health Department,
Wakefield, Yorks.

W. M. Mollison

SIR,—As one of Mollison's first students may I add these notes to the very admirable account of his life and work in the last issue of the *Gazette.* I entered Guy's in October, 1905, having already passed 1st Conjoint. The demonstrators of Anatomy were then W. M. Mollison and N. Blake Odgers, both excellent teachers; the technician was 'Doc' Hancock, who had been colour sergeant in Ian Hamilton's company of the Gordan Highlanders at the battle of Majuba.

Mollison would come into the class room and draw in chalk a perfect representation of the femur, then he would draw in the right colours the muscles, and finally put in the vessels and nerves, making a highly skilled picture of Scarpa's triangle. It was a most competent performance. Years later at a Medical Committee at his house he showed me a model sailing yacht, which he made for his son, perfect in every detail.

One night in 1909-10, I was a Dental Travelling Scholar in Berlin, there came a knock on my door; it was Mollison who was then visiting E.N.T. hospitals in Vienna and Berlin, and had taken the trouble to discover the address of an insignificant student and pay him a visit.

Yours, etc.,

F. N. DOUBLEDAY

Guys' Hospital,
London, S.E.1.

Sold Out Mini-Auditorium

SIR,—Once again, the demand for tickets for the Residents' Play has far exeeded the number of seats available. It is very gratifying to see the continued interest in the play and I would like to apologise in advance to those whose requests for seats has had to be turned down.

While we are of course grateful for permission to use the Physiology Theatre, the shortage of space in the auditorium only emphasises the perennial plea for a permanent theatre at Guy's. The re-building plans of a hospital are necessarily subject to frequent changes, but I would like, on behalf of those who have been concerned with this year's play, repeat the hope of the Theatre and Music Clubs that priority should be given to the provision of full-sized functioning stage and adequate seating to do justice to the interest and enthusiasm of the largest medical and dental student community in London.

Yours, etc.,

SIMON M. WOOD
(President of Residents)

Guy's Hospital,
London, S.E.1.

No Deafened Ear . . .

SIR,—Further to the Passim of Jan. 21st., by R.E.C. and the comments of the two consultant obstetricians who wrote in your last issue, the following story is not inappropriate.

Family Doctor: "I would like your opinion about the termination of a pregnancy."
Consultant: "What are the details?"
Family Doctor: "The father was a syphilitic; the mother has T.B. she has four children; the first was blind, the second died, the third was deaf and dumb, and the fourth had T.B. Would you terminate this pregnancy?"

If your advice had been to terminate, you would have murdered Beethoven.

Yours, etc.

R. A. KEABLE-ELLIOTT

The Doctor's House,
Stokenchurch, Near High Wycombe

Sports Section Editorial

Sir,

Ichabod.

Yours, etc.

Department of Pathology,
Guy's Hospital Medical School.

COLIN HUNTER-CRAIG

No Spoons

SIR,—Whilst I would join with Miss Taylor in congratulating Miss Andrews' comments (January 21st) condemning the rather sweeping statement in the leading article of the Nursing Section (January 7th), I would like to take the matter a little further.

I, like many others, resent the term "spoon fed"—we are *not*!

Fortunately, many who start nursing have eager, enquiring minds! I admit that many become apathetic over the months and do not follow up practical work by reading and study. This is partly due to the nurse herself and partly due to where the nurses have had the "luck"(?) to work.

One hears many an eager junior complain that when she asked a question of her seniors in relation to her work, she had been greeted with, "Oh, not now nurse, can't you see that I'm busy?"

Who can blame her for avoiding further rebuffs? On the other hand, I'm glad to say, many Ward Sisters and senior nurses are only too willing to impart any relevant knowledge (and a bit more, too) to those who enquire. These people still manage to cope with running their wards and departments and yet have time for the student nurse!

We must never separate clinical instruction from the care of the patient, because it is usually knowledge thus gained that the nurse remembers best. It is up to us all therefore—Student Nurses, Ward Sisters and Clinical Instructors to keep up the connection between the two. One further point; it is agreed by all that the high percentage of failures in the last State Examination is horrifying. According to varied reports it may be due to the poor standard of practical work—but nobody is sure. It is stated that the G.N.C. cannot tell. It is preposterous that a responsible body, such as the General Nursing Council, have no means of telling exactly how, or why these nurses failed—after all *they* are the examiners.

Surely if the matter is to be rectified in the future the answer must be found as quickly as possible, to prevent further wastage of precious time and nurses.

Yours, etc.,

MARGARET TREWELYN
(*Senior Student Nurse*)

Nurses' Home,
Guy's Hospital.

Failing and Shifting

SIR,—I was apalled to read in a recent copy of the *Gazette* in the Nursing Section under the heading 'Nursing Examination Failures' that some nurses are taking jobs to supplement their working hours and salaries. I agree that nurses should have some outside interests but surely this is going too far and is due entirely to the extra off-duty gained by working the shift-system.

Although at Guy's for nearly nine months after the installation of the shift-system I considered myself fortunate that I only worked one month on night-duty under the new system and the rest of my days as a Staff Nurse were spent on out-patients where of course the system does not apply.

May I as one who watched the effects of the installation of the shift-system from the outside say this, that since the system came into effect (1) the nurses have had to work twice as hard, as the number of nurses on a ward at any one time has been halved, the nurses therefore get far more tired and irritable. (2) the patients do not receive the care and attention they should and used to get under the old system because of the reason stated above. These I consider the most important points, there are many more I could mention but would take too long.

Surely would it not be possible for the forty-two hour week to be incorporated into the old split off-duty system of working from 8 a.m. to 8.30 p.m. long hours admittedly but none of us ever really minded working that long and if I may say so the devotion to duty was greater and the standard of nursing far higher than it is now.

Harsh words may be but I am sure many will agree with me including members of the Medical Staff.

Yours, etc.,

SUSAN F. GILES S.R.N.

Tree Tops,
50 Shorton Road,
Paignton, Devon.

Blatantly Beautifully Blunt

SIR,—It occurred to me that you might enjoy a further addition to your collection of *obiter dicta et scripta*. The following appeared as the postscript to a complaint made by a patient to a Medical Service Committee: "What I mean serious is anybody beaten burnt bleeding or pass out and cannot bring around."

I find it difficult to decide whether this splendid alliterative effort derives more from printer of from Peirs Plowman.

Yours, etc.,

J. R. MILES

Windhover,
Charlton Park Gate,
Cheltenham.

STUDENTS' CLUB

R. H. S. LANE
Student President

The Students' Club is a constituent institution of the Guy's Hospital Clubs' Union, as are the majority of the Clubs at Guy's, and all members of the Club's Union are members of the Students' Club.

The functions of the Club are to administer the Club's premises in the East Wing, to encourage and promote cultural and social activities, to provide for the representation of the opinions of medical and dental students inside the Hospital, on the Presidents' Council of the University of London Union and on official student bodies outside the Hospital, and finally to administer the Book Exchange in the East Wing. It is apparent that many people are quite ignorant of, and even hostile to the Club's activities which look straightforward enough in print, but give rise to a number of headaches in practice.

The day-to-day running of the premises is in the hands of the Student President and Secrettary. We find that students tend to vary in their regard to furniture, the telephone and in particular to the structural facilities. For the most part I believe students do respect the premises and it is only a small minority who cause trouble and inconvenience. Guy's suffers far less difficulty than do similar unions. Guy's Students, despite the camouflage of some, are not that terrible—yet!

The Club has often been accused in the past of neglecting the social activities and during the past year we have tried to remedy this. The Saturday night "Hops" have been improved with more organisation and better groups. The Inflams, monthly parties in the Bar, have proved a great success, partly because nurses, physiotherapists, etc., are made very welcome and admittance is free. The Snowflake Ball and the Folk Concert have added variety to the Club's activities. The Bar is to have a permanent steward in the near future. This step will, I hope, dispel a number of misgivings that have been expressed, and insure a smooth and efficient service. The decor needs critical reappraisal and I am sure it will be possible for some alterations to be undertaken in the near future—without a further increase in the price of beer!

The annual elections to the Students' Club Council are to be held in March. Each year is entitled to elect two student representatives, except the first year, who elect one representative. The Guy's Hostels also elect one representative. The Council meets once a month in term time at which many important decisions have to be taken which may range from closing the Bar or, to the more trivial, ordering more copies of the elusive magazine, "Men Only", for the Reading Room. The Annual General Meeting is to be held in the week following the elections. This is an open meeting and all students are entitled to attend. It is no good grumbling away in the Spit at lunch-time about the inadequacies of the Union if you don't give the only student representative body any support.

NURSING SECTION

The New Look

Following the completion of Guy's House for the accommodation of Sisters and Staff Nurses, the Governors took a decision to provide study/bedrooms for student nurses. A mock-up of the proposed room was made within two of the existing bedrooms (approximately 9ft. by 8ft.) and nurse representatives were invited to sleep there and give their opinions.

Following this experiment, Phase I of the upgrading of the Nurses' Home was begun and by the autumn of 1966 34 bed-sitting rooms were completed in the Garden Wing overlooking the Park.

The new study/bedrooms have been under review and a research enquiry was carried out among new and old room occupants. A number of constructive comments from this enquiry are being considered for the new rooms under construction in Phase II.

When one sees these study/bedrooms it is apparent that as much use as possible has been made of the space available. The furnishings are in background colours to enable the nurses to decorate their rooms with their own belongings which don't look out of place. A nurse can make a room take on her own personality and yet the rooms themselves don't look impersonal.

In Phase I two types of bed have been fitted. One is a swing-over bunk which makes a padded railway carriage type seat, and the other a pull-out divan-type bed. The general view is that the divan bed is easier to make and more comfortable than the bunk, and it only will be provided in Phase II.

Electrical fittings are in abundance. The lighting is from two indirect 4 feet fluorescent tubes with a bedhead light. There is a control switch for radio and a call button for the reception of telephone calls. There are plugs for record player or tape recorder and an aerial plug for television. There is also a call system for rising in the morning or at night.

Outside the rooms the corridors are carpeted and lined in light coloured panelling. There are two telephone kiosks—one on the internal switchboard and the other for outside calls. There are at the moment two bathrooms and one w.c. to eight rooms but when the rooms under construction in Phase II are opened, there will be more toilet facilities.

A kitchenettte has been built for each floor and contains a refrigerator with sink and a gas ring and toaster. At present there is no utility room in the new wing but plans are made for one to be included in the next building phase.

There are 60 more rooms due to be opened by July. Then plans are ready for renovating Shepherds House. The Schools of Nursing, Physiotherapy and Radiography and Radiotherapy will be housed under one roof and there will be a lecture hall and library for working in. There will also be study rooms for group work.

The main entrance to the Henriette Raphael Nurses' Home is due to be re-opened in August of this year.

The new entrance hall will have a new high-speed lift and at the back of the Home there is to be a luggage lift with a direct entrance from the Laundry Yard and access to a trunk storage room.

It is due to the combined effort of many people that Guy's nurses will soon have one of the most comfortable and modern Nurses' Homes in the country.

STAFF CHANGES AND APPOINTMENTS

NEW APPOINTMENTS

S/N S. J. Clarke (Gore Hospital, New Zealand), to Diplock Ward.
S/N J. M. Reckitt (Guy's 1962-1966), to Miriam Ward (night duty).

DEPARTURES

C/N G. King, from Hurst Ward.
S/N E. Beynon, from Addison Ward.
S/N V. Cotton, from Casualty.
S/N E. Koliasnakoff, from York Clinic.
S/N V. Lush, from Naaman Ward.
S/N C. Pert, from York Clinic.
S/N C. Rogers, from William Gull Ward.
S/N P. Rowlinson, from York Clinic.

SPORT

Repressed by respectability, afraid to offend, the Englishman eradicates the existence of Apartheid. Greedily encased by materialism, he justifies his conscience by the surrounding contentment of his family. He wants to see no further.

But Apartheid, bitter and easily pronounced, is not just food for politicians—*it is a practised code of living, a fungateous disease of humanity.*

Basil D'Oliviera has been spot-lighted for his colour and dragged into the arena to be publicly denounced. South Africa, forecasting the 1968 M.C.C. Touring XI, has expressed that she will not entertain a side that includes D'Oliviera. The M.C.C., bewildered and hesitant, retorted that in the event of South Africa objecting to the final selection of D'Oliviera then the tour would be abandoned. But Mr. Howell, with an impulsive destructive plea—for, we presume, continued friendship—added that if illness should strike D'Oliviera and therefore promote the uncalculated selection of an all-white side, the tour would continue as planned.

There the projected image of English cricket "sits on the fence", loyally yet weakly, supported by Cowdrey hitting out at Parkinson of *The Times.*

Lyn Davies (joining Rev. David Sheppard) will not go—defiance amongst the athletes marred by Mary Rand who feels that competing is always socially advantageous—Ronnie Van der Walt, a "white" professional welterweight boxer for 12 years, summoned by the Department of Interior, was stamped "black". If South Africa adopts colour as a criterion for supremacy, then we should not be bullied to compete against them in any sport.

Even within this hospital, Apartheid is an indiscretion; not material for after-dinner chit-chat. The numerous contributions that South Africans have made to Guy's are remembered with gratitude, but we cannot condone their stand or moderate our belief that Apartheid is morally corrupt.

Supporters build a defence behind comments of "mis-guided, ill-informed", but blockades as such have no foundation. They fight for time, perhaps, knowing the longer Apartheid exists the greater chance of its acceptance.

Thus the Establishment—the M.C.C.—when tested, failed.

NEWS IN BRIEF

Rugby

Coventry beat Guy's 32—8. Half-time score, 8—6 in favour of Guy's.

Guy's overpowered Old Alleynians 43—10. 2nd XV successfully emerged from the Second round of the Hospitals Cup defeating St. Mary's 11—5 on Tuesday, 14th February; they meet St. Thomas in the semi-final.

Soccer

On Saturday, February 25th, Guy's play St. Thomas in Semi-final of the Hospitals Cup at Cobham. If triumphant they meet either the London or Westminster in the Final.

Boxing

The Matt Wells Trophy is to be contested between Guy's and the Lynn A.C. at Manor Place Baths on Tuesday, 21st February.

Stop Press— Hospitals Cup—Guy's 'A' XV 9, St. Thomas' 'A' XV 9.

DIARY

Rugby Football

Feb. 18.—London Irish. Home.
,, 25.—Exeter (11 a.m.). Home.
Mar. 4.—Old Alleynians. Home.

Soccer

Feb. 17.—Eton Manor Strollers. Away.
„ 25.—U.H. Cup Semi-final.
Mar. 1.—Grossman's College. Away.
„ 4.—Manor Sports. Home.

Hockey

Feb. 18.—Gore Court. Away.
„ 25.—Sevenoaks. Away.
„ 4.—Tonbridge. Home.

Ladies' Hockey.

Feb. 18.—Royal Holloway College. Away.
„ 22. Royal Veterinary College. Home.
„ 25.—King's College. Home.
Mar. 4.—London School of Economics. Home.

Cross-Country.

Feb. 18.—Kent Hughes Championship. Jubilee Retreat.
„ 22.—Imperial College. Jubilee Retreat.
„ 25.—U.H. v. Cambridge. Jubilee Retreat.
Mar. 4.—U.H. v. Met. Police. Jubilee Retreat.

Water Polo

Feb. 23.—Imeprial College. U.L.U.
Mar. 2.—St. Mary's Hospital. U.L.U.

RUGBY

GUY'S "A" XV v. ST. MARY'S "A" XV

At Chislehurst Wednesday, 18th February

Guy's "A" XV confirmed their recent improvement with this splendid win over St. Mary's in the Junior Cup at Teddington. However, no Cup game goes as smoothly as predicted and Guy's, having driven down into the Mary's "25" in the first five minutes, watched the Mary's right-wing run nearly the whole length of the pitch to lay on a try, which was converted.

Guy's fought back and looked to have the beating of the Mary's forwards without dominating them as they should have done: however, whenever the Mary's backs ran the ball they looked dangerous—especially their right-wing. The equalizer came just before half-time when the forwards won a good loose scrum and Moore set off from the half-way line, stepped inside the wing and the full-back to score a great try under the posts: Davies converted. So at half-time the scores were level.

The second half revealed a different pattern. Dr. Burry's talk had been a shade blunter than the pre-match chat. The forwards, with Hughes giving a great lead, began to play with real fire and occasionally controlled fury —dominating the set pieces and more important the loose where the back-row were superb—their job made easy by the aggressive tackling of the centres. At full-back Davies had an immaculate game, combining enormous kicks for touch with screams of abuse and encouragement at everyone on the pitch. After 20 minutes of the second half he put Guy's ahead with a good penalty goal. The final score came close to full-time when Horsley tried to crash over, but was stopped just short of the line; the ball ran free, and Turner finished off a splendid game by picking up, running one yard, and diving over to score a wing-forwards try. Davies, strangly muted, failed with the kick. There was no need for the two points, Mary's had been well beaten at last.

Guy's: Davies; Barford, Horsley, Langley-Smith, Bundred; Scoufield, Moore; Forkes, Moss, Neville, Stoneham, Hughes, Curzon, Williams, Turner.

C. THORBURN

GUY'S v. COVENTRY

Away Saturday, 4th February, 1967
Result: lost 32—8

Coventry are one of the best sides in England this season, and their recent three games against Cardiff, Newport and Swansea in Wales had produced three wins and forty-five points to thirteen against. There was thus considerable surprise when at half-time against Guy's they found themselves down 8—6. This was enough to stimulate them to produce an exhibibtion of brilliant rugby in the second half and finish runaway winners. It was a pity from our point of view that an almost freak try broke the confidence of Guy's, after which Coventry went from strength to strength and the floodgates opened.

The first half began with both sides obtaining an equal share of the ball from all positions and play moved up and down the field. Every effort was made to keep play open, neither side gained control, and after some initial scrappy play the pattern settled down to one of repeated handling movements between forwards and backs on the part of both sides much to the delight of an appreciative crowd of about two thousand. Coventry opened the scoring with a penalty, but Guy's soon replied with a brilliant interpassing movement down the left touchline which began at half-way and ended with a try half-way out, which Elliott converted. Open play continued and a

Coventry try and Guy's penalty made the score 8—6 at half-time.

Although the style of play was attractive it was obvious that Coventry were not dominating the game and as soon as the second half began it was apparent that they had changed their tactics completely. The game became tight, the ball was repeatedly worked up the touch-line, a series of hard forward mauls followed and slowly the powerful opposition forwards began to take command. Soon Guy's were hardly winning the ball cleanly from any position, but in spite of this, being quick on the loose ball allowed us to share territorial possession and mount dangerous attacks. During one such attack on the opponents' twenty-five, the Coventry full-back attempted a long clearance kick, the ball being touched by a Guy's hand as it left his boot. This deflected the ball back into play, put all the Coventry players on side, and in the distance on the Guy's twenty-five, many yards from the rest of the players, a grateful Coventry forward picked himself up off the ground, caught the gift from heaven and ran over the line to score. This was converted and a minute later a penalty nearer the posts added to their score. This sudden change in fortunes crushed Guy's confidence and the opposition won all the ball and were allowed to attack again and again. The Guy's tackling lacked determination and brilliant Coventry moves led to three goals in the last fifteen minutes. With a penalty their total reached thirty-two.

Guy's: D. R. Eliiott; D. A. G. Barford, J. F. Price, B. J. Rowlands, J. R. M. Ross; A. Scourfield, P. G. F. Swift; J. E. Davies, G. B. Hey, A. J. Kingdon, J. M. Cockburn, C. G. Neville, D. A. Curzon, H. C. Sharp, C. W. Thorburn (Capt.).

S. COOK

HOCKEY

GUY'S v. WALTON

Saturday, 11th February, 1967

Result: lost 5—2

After an improvement in their hockey in the last few matches, Guy's slumped badly against Walton. They had no answer to the faster and harder Walton forwards and halves who dominated the midfield.

The first half saw Walton with a 3—0 lead —each of their inside trio scoring good goals. Guy's had two good chances to score but the finish in front of goal was lacking.

During the second half other people, apart from Appleby and Pearson who had set a fine example, began to show some enthusiasm. This lead to Steer netting the ball only to be judged off-side. Walton came back quickly and scored a very good goal with a shot from the top of the circle. Guy's continued to try and get on terms and eventually Dodd scored after Appleby had made the running down the left. Walton's fifth goal came when they were given a goal by a weak clearance from in front of the goal, which went straight to an advancing forward. Guy's scored another goal just before full-time. They could have had more goals in the second half but for weak finishing and a very fine display of goalkeeping by the Walton goalkeeper.

This was a completely unsatisfactory game for Guy's. The team, as a whole, played as if thy hadn't any real interest in the game and were merely there for the runabout. Until this attitude changes and players revert to the spirit of early October, when maximum effort was given by all, then we can only look forward to a further series of defeats and a rapid fall in the standard of our fixtures.

Guy's: C. Calder; D. Loader, D. Crafts; R. Kindrick, M. Vellacott, C. Pearson; D. Steer, N. Dodd, M. Appleby (Capt.), H. McMichem, S. Cripps.

R. W. KENDRICK

SOCCER

GUY'S v. ST. BART'S HOSPITAL

At H.O.P. Wednesday, 1st February, 1967

Result: won 6—1

Guy's kicked off in very muddy conditions, needing a victory to keep up their championship challenge.

The ten men of Bart's troubled the Guy's defence in the early part of the game, and their early pressure resulted in a goal, helped by a defensive mistake. The arrival of the opposition's eleventh man was a turning point in the game, for, as the first half wore on, Guy's pressed hard at the Bart's goal and were rewarded by a fine goal by McClure, after a good movement on the right wing. Guy's went close to scoring again on several occasions, but the interval score was 1—1.

In the second half Guy's adapted themselves to the conditions much better than their opponents, and not long after the restart they took the lead through Lindridge, who rose high to meet a free kick and head into the net. Guy's were now playing impressive football in spite of the conditions, and their quick passing tired the opposition. Two quick goals, by McClure and Lindridge, settled the issue as a contest, both goals resulting from closely-worked moves. Guy's newly-initiated 4-2-4 formation was now working well with more running off the ball than previously. Two more goals by Lindridge, bringing his total for the season to 27, gave the final score of 6—1.

This was an encouraging victory by Guy's who overcame the conditions and a poor start to emerge as clear victors. The side has now gained 11 out of a possible 14 points in the United Hospitals' League, and with continued success, must stand a very good chance of winning the Championship. In addition, Guy's, the holders, are still in the U.H. Cup, meeting St. Thomas's Hospital in the semi-final on Saturday, February 25th.

Guy's M. Carter; R. Davey, S. Poole; S. Watt-Smith, R. Lovell, D. Lindridge; I. Nash (Capt.), D. Jacobs, I. McClure, E. Elias, R. Leeburn.

R. LOVELL

U.H. League

Away Saturday, 4th February, 1967

GUY'S v. THE LONDON

Result: drew 0—0

Guy's, after an emphatic series of victories in their more recent matches, anticipated a hard game against their victims of last seasons Hospitals' Cup Final.

The game began in brilliant sunshine with the pitch firm and fast, conditions expected to suit the swift Guy's team. The early play was slightly careless with both teams testing each others' strengths, quite literally in the case of the London's heavily-built defences' tackles on the smaller Guy's forwards. Soon Guy's slick interpassing made more openings and an expertly-flicked goal by Lindridge from a right-wing cross was disallowed as a result of a fractional off-side decision.

Play became more rough as the Guy's half-backs tackled the opposing forwards in a rather aggressive manner. Some dangerous centres by the London's right-wing were cleared by solid headwork by Watt-Smith, the cultured Guy's centre-back; and some robust tackling from Poole. The half-time whistle came with Guy's pressing but unable to obtain a break-through even after they had forced a series of corners.

The London came more into the game in the second half as they played with the wind behind them, and Carter, the agile Guy's goalkeeper, was called upon to exert himself more than he had become accustomed to in the previous matches. The last quarter of the game was more evenly fought with some powerful right-wing runs by Davey fizzling out near the (London) penalty area. A farcical offside decision by the referee robbed Guy's of a probable goal when Lovell, the diminutive (mid-field) link man was about to push the ball through n the right to an unmarked forward.

Heavy tackling and close marking by the London had quoshed any chance of open foot-ball and they grew more desperate in their rather stereotyped attacks. Full-time came just as play threatened to degenerate into an open brawl but Guy's had done enough to earn an important away point.

R. LEEBURN

Guy's: M. Carter; R. Davey, S. Watt-Smith; I. Nash, P. Evans, S. Poole; R. Lovell, D. Jacobs, D. Lindridge, I. McClure, R. Leeburn.

WATER POLO

GUY'S v. ST. MARY'S II

Tuesday, 31st January, 1967
Result: won 5—0

For the whole of the first quarter we showed virtually no signs of attacking, Froom being the only player to move about when we had possession. But the defence was quite sound and Howard proved he could save any long shots that Mary's attempted.

With a complete change to attack in the second quarter we dominated the play and opened the scoring. Froom was still particularly active, and as he received more of the ball and with the advantage that we were attacking the deep end, his breaks led to goals by himself, Challacombe and Northcott.

We continued to dictate the play in the third quarter, and with the 3—0 lead the game seemed quite safe. Mary's defence had improved though, and a shooting famine ensued which was relieved only by one good goal by Challacombe.

In the final quarter Mary's crowded their defence, which only allowed long shots, but one of these rebounded from the goalkeeper and was pushed in by Froom. Towards the end Mary's managed to apply some pressure but could not worry our defence enough to score.

Guy's K. Howard, J. Wood, D. Foulds, M. Adkins, G. Northcott, A. Froom, B. Wright, S. Challacombe, P. Ashford.

G. NORTHCOTT

U.L.U. League, Div. II
GUY'S v. BATTERSEA

Thursday, 2nd February, 1967
Result: lost 2—3

Guy's found their stiffest opposition so far in last year's winners of this division. Battersea quickly took the lead by scoring two goals in the first quarter—both due to slack marking by the Guy's defence. However, in the next quarter Guy's settled down, and the marking tightened. The half-backs were breaking better, and soon the score was level from goals by Challacombe.

In the third quarter there was no score, although Guys missed a penalty, and the result looked a draw when in the last minute of the game Battersea scored, although Guy's had wasted several scoring chances at the other end.

Guy's: J. Wood, D. Fould, A. Froom, M. Adkins, G. Northcott, A. Forbes, P. Ashford, S. Challacombe.

HOSPITAL INFORMATION

APPOINTMENTS VACANT

GUY'S HOSPITAL, S.E.1.

Applications are invited for the post of **Registrar in Ophthalmology** (two sessions per week) with appointment from 1st April—30th September, 1967, in the first instance. Forms of application are obtainable from the Superintendent, Guy's Hospital, and should be returned not later than **28th February, 1967.**

BOARD OF GOVERNORS OF GUY'S HOSPITAL AND SOUTH-EAST METROPOLITAN REGIONAL HOSPITAL BOARD

Registrar in Psychiatry

Applications are invited for the above post, to be held jointly at St. Olave's Hospital, S.E.16, and Bexley Hospital, Kent. The Department of Psychological Medicine at St. Olave's Hospital offers in-patient, day patient and out-patient facilities in a busy general hospital. Opportunity will be provided for study and experience in developing community service involving links with Guy's Hospital. Experience in special problems and rehabilitation will be provided at Bexley Hospital, which is a modern adult psychiatric hospital.

Candidates may be resident or non-resident and should have previous psychiatric experience. Duties commencing as soon as possible, and appointment until 30th September, 1967 in the first instance.

Forms of application are obtainable from the Superintendent, Guy's Hospital, S.E.1, and should be returned not later than **28th February, 1967.**

GUY'S HOSPITAL MEDICAL SCHOOL

Applications are invited for the post of **Junior Lecturer/Lecturer in the Bacteriology Department,** starting on 1st April, 1967, or as soon as possible thereafter; applicants should hold a medical qualification. Salary range £1,400—£2,535 according to qualifications and experience (subject to review). Forms of application are obtainable from the Dean, Guy's Hospital Medical School, S.E.1, and should be returned not later than **11th March, 1967.**

GUY'S HOSPITAL, S.E.1.

Applications are invited for the post of **Dental Officer** (General Dental Practitioner grading) to carry out the dental treatment for In-Patients in collaboration with the Dental Consultants and with attendance on six sessions per week. Surgery Assistant provided. Duties to commence as soon as possible. Forms of application are obtainable from, and should be lodged with, the Superintendent, Guy's Hospital, S.E.1, not later than **Friday, 3rd March, 1967.**

HOUSE APPOINTMENTS

GUY'S HOSPITAL
March 1st, 1967

House Surgeons
To:
Mr. Eckhoff — Mrs. I. M. J. Mathias
3 *months*
Professor Atkins — Mr. R. J. Morgan
6 *months*
Mr. Wass — Mr. H. J. Sturzaker
3 *months*
Mr. Blackburn — Mr. A. P. Warin
6 *months*
Mr. Lawrie — Mr. M. J. Light
6 *months*
Mr Glover — Mr. P. G. Ransley
3 *months*
Mr. Brain — Mr. P. B. Ashcroft
6 *months*
Mr. Beard — Mr. A. Bevan Jones
3 *months*

House Physicians
To:
Dr. Mann, — Miss L. M. Rikard-Bell
Dr. Scott and — 3 *months*
Dr. Bishop — Mr. A. Aynsley-Green
6 *months*
Dr. Hardwick, — Mr. C. A. Soutar
Professor Trounce and — 3 *months*
Dr. Deuchar — Miss D. C. Phillips
6 *months*
Dr. Baker, — Mr. M. F. D'Souza
Dr. Houston and — 3 *months*
Dr. Grimble — Mr. R. K. Jacoby
6 *months*
Dr. Kauntze and — Mr. J. D. Powell-
Dr. Joiner — Jackson
3 *months*
Mr. C. J. Davies
6 *months*
Professor Butterfield — Mr. R. A. J. Spurrell
and Dr. MacLean — 3 *months*
Mr. J. V. Collins
6 *months*

House Surgeon to the Surgical Unit
Mr. D. Tong
3 *months*

Gynaecological House Surgeon
Miss A. de C. Evans
6 *months*

Throat and Ear House Surgeons
Mr. R. S. B. Bramwell
3 *months*
Miss R. A. Baker
6 *months*

Orthopaedic House Surgeons
Mr. J. R. C. Sharp
3 *months*
Mr. N. A. Watson
6 *months*

Genito-Urinary House Surgeon
Mr. J. F. Searle
3 *months*

Children's House Physicians
Mr. J. M. Brummitt
3 *months*
Miss C. M. Holliday
6 *months*

House Physician to Dr. Bishop, Dr. Wayte and Mr. McArthur
Mr. R. J. Eady
6 *months*

Casualty Officers
Mr. J. de Nobrega
3 *months*
Mr. J. S. Gregson
6 *months*
Mr. J. R. Hockey
6 *months*
Mr. B. McGuirk
3 *months*
Mr. A. E. McKinnon
6 *months*
Mr. P. J. Metzner
6 *months*

Resident Obstetricians
Mr. T. N. D. Peet
3 *months*
Mr. A. W. J. Medhurst
6 *months*

Neurological House Physician
Mr. R. A. Y. Pietroni
6 *months*

Dermatological House Physician
Readvertised
6 *months*

House Physician in Child Psychiatry
Readvertised
6 *months*

House Surgeons to the Thoracic Unit
Mr. T. H. Guerrier (S.H.O.)
6 *months*
Mr. D. H. Enderby
3 *months*

House Physicians in Clinical Pathology
Miss C. Surin
3 *months*
Mr. D. Leng
3 *months*

House Physicians in the Department of Psychological Medicine
Mr. S. Bhanji — 1.3.67—30.9.67
Mr. B. H. Anstee — 1.3.67—30.9.67

R.M.O.s in Nuffield House
Miss H. Kerr — 1.1.67—30.6.67
Mr. A. J. Richards — 1.3.67—31.8.67

Resident Anaesthetists
Mr. M. S. Vernon
3 *months*
Mr. P. A. D. Williams
3 *months*
Mr. I. A. Sutherland
6 *months*
Mr. M. C. W. Morgan
6 *months*

Children's House Physicians at the Evelina Hospital
Mr. J. R. T. Gabriel — 1.10.66—31.3.67
Mr. R. A. Sturge — 1.12.66—31.5.67
Miss J. C. Summerscale — 1. 2.67—31.7.67
Mr. B. C. O'Moore — 1. 4.67—30.9.67

Casualty Officer at the Evelina Hospital
Mr. S. C. D. Mehta
6 *months*

ST. OLAVE'S HOSPITAL

House Physician to Dr. Mason and Dr. Cox:
Miss H. Hale
3 *months*
Mr. P. Bowen-Simkins
6 *months*

House Surgeon to Mr. O'Flynn:
Mr. J. M. Richards
3 *months*

House Surgeon to Mr. Lewys Lloyd (S.H.O.):
Mr. J. Barnes
3 *months*

House Physician to Dr. Cox (S.H.O.):
Mr. K. Sheth
7 *months*

Gynaecological House Surgeon (S.H.O.):
Miss S. E. Cox
6 *months*

Casualty Officer (S.H.O.):
Mr. B. C. Rosenberg
3 *months*

NEW CROSS HOSPITAL

House Physician in Medicine and Geriatrics (S.H.O.):
Mr. D. J. Ewing
3 *months*
Mr. D. F. H. Wardle
3 *months*
(S.H.O.):
Mr. B. J. Mason
6 *months*
Mr. C. C. Penney
6 *months*

Orthopaedic House Surgeons:
(S.H.O.):
Mr. Elmariah
3 *months*
Mr. J. E. Davies
3 *months*

S.H.O. to the Rehabilitation Unit:
Mr. M. L. Ingpen

P. J. HELLIWELL,
Superintendent

February 8th, 1967

PASS LIST

EXAMINING BOARD IN ENGLAND

Final Examination, L.R.C.P., M.R.C.S.

Surgery

P. L. Almot
*A. Aynsley-Green
*Rosemary A. Baker
*D. L. Beales
*E. J. Bowen-Jones
*S. A. L. Ceesay
*C. J. Coffin
*J. C. Crisp
B. W. Eliot
*Ann De C. Evans
*D. P. O. Griffiths
*N. C. Hamblyn
*C. I. P. Havers
*Sally M. Haslewood
*Christine M. Holliday
*R. K. Jacoby
*J. P. H. Jago
R. P. Juniper
*K. Kermani
*A. J. Kingdon
*P. R. Kirby
*A. Kumar
*R. J. Leete
*M. J. Light
W. D. McNicoll
*Jill Paling
*Diana C. Phillips
*M. A. Preece
*Rita C. Radford
*D. S. Robins
*D. A. Ryland
*J. D. Salomon
*Hilary M. Scott
*J. D. Stephens
*Clare A. Stevenson
*D. B. Stewart
*Anthea C. D. Sutton
*A. L. Thomas
J. H. Topham
*P. J. C. Trenchard
*D. R. H. Vernon
*A. P. Warin
*N. A. Watson

Pathology

J. T. H. Anderson
R. C. Bucknall
A. P. Freeland
R. P. D. Hancock
M. J. Lockwood
R. F. J. Matthews
E. A. O. Orebiyi
A. H. Osborne
A. J. M. Proctor
K. H. Riding
R. C. G. Rowe
D. Stratton
E. N. Turfitt
*D. R. H. Vernon

Medicine

*E. J. Bowen-Jones
A. G. D. Budhall
J. R. K. Butchey
R. S. Carruthers
J. H. W. Davies
A. J. Hamilton
N. Irish
J. N. MacLean
R. F. J. Matthews
D. J. Osborne
A. J. M. Proctor
R. H. Williams
J. M. Worms

Midwifery

N. M. Bannerman
A. G. D. Budhall
A. P. Freeland
A. J. Hamilton
R. A. C. Hughes
N. Irish
P. J. Leopard
M. J. Lockwood
I. N. Mallah
*R. J. Morgan
D. J. Osborne
K. H. Riding
R. C. G. Rowe
D. Stratton
*D. R. H. Vernon
J. L. Williams
P. M. Wood
J. W. Wright

**Have now completed examination*

CHANGES OF ADDRESS

Mr. R. J. Cann, Wonham Cottage, Wonham Lane, Betchworth, Surrey (Reigate 42183). Consulting rooms in the Superintendent's House (HOP 3351).

Dr. K. R. J. Coates, 75, Moreton Hall, 253, North Ridge Road, Durban, Natal, S. Africa.

Dr. and Mrs. Grahame P. Coleman, Jacqueline and Helen, Glenfield House, St. Teath, Bodmin, Cornwall.

Dr. N. A. Harker, Chesterton Copse, Cirencester, Glos.

Dr. M. P. Wilderspin, Westmains, Lime Tree Road, Matlock, Derbyshire.

PERSONAL

GUY'S L.D.S. has charming villa, Mijas, Malaga. Perfect four persons. Maid, swimming pool, gardens. Sell or let. Probert, 10, South Street, St. Austell.

MAJORCA. SANTA PONSA. Furnished flat to let March/May; part July; and September onwards. Sleep 4/5, two bathrooms. Terrace. Air conditioned. 100 yards sandy beach. Box No

BIRTHS

DOMAINGUE—On 17th January, 1967, to Rosemarie (née Webb, S.R.N.) and Jacques Domaingue, a son (Jean-Marc).

HYDE-WHITE—On January 28th, at Guy's Hospital, to Hilary (née Young), and Michael Hyde-White, a son, Walter Reginald.

WILDER—On 21st December, 1966, at the Royal Northern Hospital, London, to Joan (née Mitchell) A.R.M.C.M. and Leonard Wilder, B.D.S., a son, Lucien, a brother for Andrea.

We would like to remind our readers that all copy for inclusion in the Gazette must be received eight days before the publication date.

Birth, Marriage, Death and Change of Address notices are without charge to subscribers. For Personal notices the charge is £1 1s. 0d. for 15 words, additional five words 10s. 6d. minimum 15 words. Non-subscribers will pay £1 1s. 0d. for all notices other than Personal

GUY'S HOSPITAL GAZETTE

EDITORS D. S. ROBINS and C. B. BROWN
SPORTS CORRESPONDENT J. G. PAYNE
NURSING CORRESPONDENT E. A. MALPAS

FORTNIGHTLY TWO SHILLINGS VOLUME 81 NUMBER 2051

PASSIM

Wills Library Bulletin

For the many who find the Wills' Library a sea of innumerable publications whose whereabouts, and actual presence, if one doesn't have the time to spend searching, can only be obtained by badgering the library staff, the newly-published Bulletin will be greatly welcomed. It is to the credit of the Librarian that the needs of those who use the library for more than just to peacefully peruse their copy of *Playboy*, or copy out the lecture notes of a friend, have been recognised as completely as the first number of the Bulletin has shown. Apart from giving an explanation for the piles of books and cardboard boxes that have been hindering movement recently, it contains information on new subscriptions that have been placed on a number of journals and a list of recent additions that gives a far more adequate service than the small notice-boards hitherto used. The most enterprising section, however, is a bibliography of recent publications in two spheres, on this occasion Intensive Care and Complications During Pregnancy. The usefulness of this last section, as it continues to cover more and more fields, we feel sure will come to be highly appreciated by the many who find the search for suitable reading references one of the most exhausting parts of article writing.

The Bulletin also announced a Seminar on Information Dissemination in the Anatomy Theatre last Wednesday at 2.30 p.m., which was arranged in conjunction with the Institute of Scientific Information. This proved to be highly enlightening, for the problem continues to grow in severity. On page 109 we print a review of a recent publication which dealt with this particular problem.

False Economy

Last week a retrogressive step was taken in educational legislation. Mr. Anthony Crosland, Secretary for Education and Sciences, increased the fees for overseas students from £70 per year to £270.

Mr. Crosland is, of course, primarily concerned with the increasing subsidy his department has to give to the 71,000 overseas students in Britain, a subsidy which has risen from £10 millions to £18 millions

in the past five years. He asserts that this subsidy is "open-ended", and that there is no other way to control it than that which he has proposed. This is not true. Nor is it true that the Robbins Committee would agree with what he has done. This Committee favoured an increase in fees from 10 to 20 per cent of the costs, but emphasised that any increase ought to be general. In addition, the Committee also considered with the Treasury, the book-keeping problem which Mr. Crosland seems to have found insoluble—that is, how to compensate the local authorities, who pay most British students' fees, for the extra money they would have to disburse if fees were raised all round. They found no real administrative objection to a uniform increase in the fees. Mr. Crosland states that this would result in an £8 millions increase in the rates and therefore could not be regarded as a serious proposition. The Secretary would do the country a service by stepping across to the Treasury and finding out the facts.

Britain plays an invaluable role in the Commonwealth by providing university education and post-graduate facilities which may be viewed as one of the most important forms of aid to those developing countries who are sorely in need of trained men and women in all spheres. Mr. Crosland's reply to criticisms of his move that students would not be deterred, or developing countries harmed by this fourfold increase in the fees shows an inconceivable ignorance on his part of the magnitude of this rise.

The reaction this proposal met with in academic circles was one of general disgust, which was followed-up by widespread criticism of the Government's decision. However, it appears from Mr. Crosland's statement that the University Grants Committee was not against the idea in principle One wonders in whose interest this Committee serves to accept such a preposterous suggestion.

Foreign students should not be made to pay more for their tuition simply because they are foreigners. This is discrimination. The price of learning should be the same for everyone, no matter where they come from.

We congratulate Dr. I. Kelsey Fry on his appointment as consultant radiologist to St. Bartholomew's Hospital.

We also congratulate Mr. Ian McColl on his being awarded the Moyniham Fellowship for 1967 by The Association of Surgeons of Great Britain and Ireland.

GUY'S DIARY

MARCH			EXHIBITION in the Gordon Museum—BREAST CANCER.
6th	M.	1.00	Clinical Lecture. Mr. MURRAY FALCONER. "Anterolateral Ichordotomy for Pain."
		8.30—2.0 a.m.	Inflam No. 4, Students' Bar.
7th	Tu.	1.00	Clinical Lecture. Dr. MANN. "Bright's Disease."
		5.00	Medical Genetics Series: In the Anatomy Theatre. Dr. J. FRAZER ROBERTS: "Common Congenital Defects II."
9th	Th.	1.00	Clinical Lecture. Dr. HUTTON. "The Post-Operative Complications of Anaesthesia."
10th	F.	1.00	Clinical Lecture. Mr. BRAIN. "The Surgery of Diffuse Pulmonary Disease."
13th	M.	5.00	Medical Genetics Series: In the Anatomy Theatre. Professor R. KNOX: "Inheritance in Micro-Organisms I."
14th	Tu.	5.00	Medical Genetics Series: In the Anatomy Theatre. Professor R. H. GORRILL: "Inheritance in Micro-Organisms II."
16th	Th.	1.00	Clinica Lecture. Dr. HARDWICK. "Oral Anti-Diabetic Agents and the place of Phenformin in the Treatment of Diabetes."
		5.00	Neurosurgical Round. Mr. PETER SCHURR. Clinical Theatre.

ANNUAL CLINICAL DENTAL MEETING, 4th MARCH, 1967

ANATOMY LECTURE THEATRE, MEDICAL SCHOOL.

11.45 a.m. Lecture: Fluoride-containing Toothpastes; a three-year clinical assessment - Dr. M. N. Naylor.

THEATRES Nos. 3 and 4 (FIRST FLOOR, NEW GUY'S HOUSE).

Operations commencing at **10.0 a.m.**

There will be DEMONSTRATIONS AND DISPLAYS in all the Departments of the School. Some members of the Visiting Dental Staff will show clinical cases on the second floor, Dental Department.

DENTAL LECTURE THEATRE.

2.30 p.m. Lecture: Cases You Have Sent - Professor R. A. Cawson.

There will be DEMONSTRATIONS AND DISPLAYS in all the departments of the School.

TEA will be served in the Cafeteria, East Wing, Guy's House, at 3.30 p.m.

Programmes giving full details will be available at the Clinical Meeting.

NOTICES

Guy's Hospital Nurses' League

In view of revised plans for nurse education and the discontinuation of a compulsory fourth year of training, the League Council has agreed that nurses who trained at Guy's but left the hospital without completing their contract, may now apply for League membership. Details and application forms from: Matron, Guy's Hospital. (Please mark the envelope "A".)

THE NON-SURGICAL TREATMENT OF PERIODONTAL DISEASE

J. O. Forrest, F.D.S., R.C.S.Eng.

Department of Preventive Dentistry.

Non-surgical therapy

The periodontal tissues may be influenced for good or ill by all the procedures which are carried out in dental practice. Thus a comprehensive assessment of non-surgical techniques should include all those aspects, such as restorative dentistry, endodontics, prothetics, and orthodontics, but space will permit only a selection and consideration of the more important phases. Periodontal disease may be acute or chronic. The vast majority—probably 95 per cent or more of cases that present in practice all over the world are of the chronic type and it is thus fitting that this should receive the major consideration here.

The objects of treatment may be summarised as :—

(a) Elimination of the periodontal lesion;
(b) Elimination of aetiological factors;
(c) Restoration of physiological gingival and bony architecture;
(d) Elimination of gross occlusal disharmonies;
(e) Maintenance.

In order to achieve these ends a thorough history in all its aspects, a complete oral examination, including X-rays and an evaluation of the attitude of the patient must have been carried out. It is important to have a concept of complete treatment, to treat a whole patient, a whole mouth, a whole case. Lacking an overall plan, the dentist will go from one expediency to another and will subject his patient to procedures that may be inadequate, overprolonged or unnecessary.

In general, a standardised pattern of examination should be followed so that the operator is able to make accurate case comparisons and be aware of the results of his treatment.

When the dentist has obtained all the information necessary, the definitive therapy can be planned.

Where gingivitis or periodontitis is recognised in the early stages and the fibrosis produced by long standing inflammation has not occurred, treatment may be entirely non-surgical. When the lesion has been allowed to become more advanced both non-surgical and surgical techniques will probably need to be applied. It should be stressed here that this is not a debate on the respective merits of different forms of therapy, surgical and non-surgical. These are both complementary aspects of total treatment and are all stages in the attack on the periodontal lesion.

(a) **In the elimination of the chronic periodontal pocket treatment** may be performed in two stages, as initial therapy and as completion therapy after further evaluation.

Initial therapy includes scaling, root planing, oral hygiene training (not *instruction*—but training), preliminary splinting if necessary, and attention to any systemic disorders which should be evaluated, with corrective therapy arranged by the patient's physician, if possible. Gross occlusal discrepancies should be corrected.

There may be, consequential to thorough application of the preceding measures, a complete return to normal in uncomplicated cases. This will not be a permanent result unless the previously ascertained aetiological factors are eliminated. Thus, the diabetic should be referred for blood sugar control so that the gingivae will be in optimum condition for response to the adopted operative techniques, and scorbutic gingivitis (to choose a rare but dramatic example) would require attention to the diet, and attainment of high ascorbic acid levels in conjunction with the scaling and oral hygiene programme.

Scaling is the most important operative procedure in periodontal therapy and entails the complete removal of all calcific deposits, debris and plaque from the teeth.

It is essential to emphasise the complete removal. There should be no variations in scaling such as coronal scaling or root scaling. Unless calculus removal is complete, total resolution of inflammation will not occur. The procedure should be carried out even if surgery (e.g. gingivectomy) is planned because the marked reduction in inflammation and pocket depth will contribute to the ease of the subsequent operation. When scaling is performed as part of initial therapy the co-operation of the patient can be evaluated, and if this is unsatisfactory, and continues to be so, then follow-up surgery will probably be a waste of effort.

There are many instruments available for scaling and the choice of suitable designs is a personal one. However, the dentist should limit himself to relatively few instruments which he has mastered rather than drawers full of rarely used exotic designs.

An acceptable set of scaling instruments may consist of a chisel type (G1 or Zerfing) used with a push motion, sickle types (Jacquettes 1, 2, 3, preferably tungsten carbide), hoes (British tungsten carbide 210, 211, 212, 213) and curettes (about 4 of the Gracey type).

The ultrasonic scaler has been used with success, and a needle brazed to the tip of the instrument makes a satisfactory scaler. The copious flushing action through the area may be beneficial. However, the ultrasonic machine does not replace hand scaling—both are used in conjunction.

Complete removal of all deposits on the teeth is a difficult and tedious task. It may take many visits, and is unfortunately frequently terminated when the coronal surfaces of the teeth appear clean. There should be frequent exploration of all the accessible root surfaces with one of the special calculus probes, combined with examination of the colour and form of the tissues to ascertain the necessity of further

instrumentation. The result of elimination of irritant deposits will be a shrinkage of the tissues and this may make deeper deposits visible and accessible. Hence the necessity for a number of visits.

Minute areas of cemental resorption may become filled with deposits and to eliminate these the root surfaces should be planed smooth, usually with hoes or curettes. All the tooth surfaces should be polished with rubber cups and pumice, and on the interdental surfaces polishing strips should be used. Highly polished surfaces will prevent or diminish further deposition of calculus.

The use of curettes in root planing may frequently result in some soft tissue curettage, but this is usually planned as a separate operation under local anaesthesia.

Training in the practice of oral hygiene methods should be instituted early and should continue until the patient can demonstrate that he can and does carry out the routine necessary to restore and maintain his gingival health. The most effective instrument in oral hygiene is the toothbrush. Considerable patience and time must be devoted by the dentist or hygienist to teaching its use. It may well be that some early gingival diseases resulting from debris accumulation respond dramatically and completely to this therapy alone.

The patient is not only shown *how* to brush the teeth but WHY. Disclosing solutions or tablets are invaluable in this respect as they may perhaps demonstrate to the patient (and sometimes to dentists) for the first time, that the cleansing methods used up to that time were inadequate. Toothbrushing techniques should be suitable to the individual patient. The "roll" technique suits the young patient but is a difficult manual skill to acquire. Charter's technique may be indicated for those patients in which there has been some gingival recession and loss of papillae. Many patients have difficulty in executing brushing techniques and it may be that simple motivation—demonstrating the plaque on the teeth with disclosing agents and then instructing the patient to brush it off in the best way he can—giving him a supply of disclosing agent—may often meet with success. The automatic toothbrush is invaluable for those who are unteachable, manually undexterous, too lazy or handicapped. However, those few of the population who have mastered and practise efficient manual brushing will gain little benefit except time from automatic brushing.

The use of *Wood points* (Stimudents) may be advised and demonstrated where there is permanent loss of interdental gingival tissue. Used effectively they not only keep the spaces free from debris but play a part in modifying the gingival form. Some keratinization may take place.

Irrigation outfits. There are many commercial irrigation appliances on the market but they all appear to have a limited value except for the removal of gross and loose debris. There would not seem to be one that removes adherent plaque from the teeth anything like as well as the toothbrush.

Other interdental stimulators may be in the form of rubber tips on special handles. These have the advantage of additional access from palatal and lingual aspects. There are many variations of this type.

Poor oral hygiene associated with drying of the gingivae resulting in gingival hyperplasia may develop in those with incompetent lip seal. The use of surgical tape, or oral screens made of acrylic, with a breathing tube incorporated if necessary, is usually helpful in maintaining salivary flow over the gingivae at night. Vaseline does not seem to be effective although advocated by some.

There should be constant reappraisal of the patient's practice of home care, and, if necessary, retraining until there is an absolute certainty that this is being carried out meticulously. Failing this, all the therapy that is performed, whether surgical or non-surgical, will be completely wasted and any favourable result obtained will be a temporary one.

An awareness of the differing response of the gingival tissues to the presence of calculus and debris is important.

Some patients will show dramatic inflammation in the presence of minute traces of debris visible only on staining with disclosing agents. Others may have enormous deposits with little gingival breakdown. Exaggerated response may occur with conditioning factors such as pregnancy. Thus a fixed recall time for all patients would not suffice. The recall interval must be geared not only to the rapidity of deposition but the rapidity and severity of the resulting inflammation. Some patients may have to be re-examined at the maintenance phase even 4 times per year or more.

The elimination of aetiological factors

The results of poor or inadequate dentistry are among the most frequent factors in periodontal disease. Poor and open contacts between teeth lead to food impaction and may be accentuated by plunger cups in opposing teeth. It should suffice to enumerate these factors. The remedy will be obvious. The elimination of filling overhangs may be a problem which may be solved by temporary filling or the use of the ultrasonic machine, or failing this long tapered finishing burs may be used.

Marginal ridges should be created where necessary on crowns to improve food spillways.

The partial denture, especially the plastic completely tissue-borne type, is a potent cause of periodontal breakdown. This occurs in three ways—by direct impingement on the gingivae—the gum stripper; by the encouragement of stagnation areas; and by exerting unfavourable occlusal stresses on abutment teeth. Again the solution is the obvious one of constructing well-designed dentures, preferably of the skeleton type with stress breakers, if indicated.

The role of **occlusal factors** in periodontal disease has been the subject of much contention between those holding differing views in this field. But most periodontists probably agree with the following generally current concepts. In the healthy periodontal state the effect of excessive occlusal stress is usually reversible and it does not initiate pocket formation or inflammation. Therefore the so-called prophylactic grinding of teeth in the healthy condition is not recommended unless *other* conditions indicate it. It is important not to awaken in the patient an awareness of his occlusion because once this is aroused

it is difficult to stop grinding a tooth somewhere because the patient will continue to discover high spots for the dentist to remove. Therefore, the patient's negative occlusal sense must be preserved. But the effect of excessive occlusal loading on periodontal structures already weakened by disease and loss of alveolar support will be an acceleration of the destruction. This becomes even more apparent as recession continues and the crown/root ratio becomes greater and thus less favourable to the stability of the tooth. With progressive alveolar loss the amount of tolerated stress becomes less, and thus a vicious spiral of destruction may be set up. Thus it is an important part of therapy to correct gross occlusal disharmonies but in general only the simplest discrepancies are capable of being tackled by the average practitioner. Since it takes an expert to recognise the simple, the grinding of occlusal areas of the dentition should be approached with caution.

Occlusal interferences may be detected by direct vision, by palpation during mandibular excursions and by the use of coloured typewriter ribbon or thin wax strips, adhesive on one side.

Migration of teeth may place them in a position where they are subjected to excessive loading and apart from the necessities of aesthetics, is a forceful reason for the restoration of these teeth to their original arch position by minor tooth movement. This may be carried out by simple removable appliances with arch wires, or elastic bands may be used on their own, but care must be taken to ensure that the latter do not slip down to, or under the gingiva. More complicated tooth movements should be assessed by an orthodontist. As a general principle periodontal treatment should be completed before tooth movement in order to eliminate the factors responsible for the original migration.

Many female patients, although they desire correction of misplaced teeth, object to the display of labial arches and wires, and in some cases it may be possible to use simple appliances.

Splinting. It is frequently necessary to stabilize excessively mobile teeth before therapy can be performed. Stainless steel wire, with or without cold cure acrylic covering, is the most common temporary splinting material used, especially in the anterior region. The posterior teeth may be splinted by using welded orthodontic bands.

The different forms of splinting must be emphasised:—

1. Temporary—in the initial phase;
2. Permanent, following therapy, and they may be either fixed or removable.

Splinting alone is not a treatment of periodontal disease. It cannot cure the lesion.

If splints are applied without definitive therapy being performed there is a danger that the patient will have a false sense of security in that his once mobile teeth are firm and he feels that his condition has been corrected although the pathology is still present. But splints may allow the tissues around a weak treated tooth to recover so that it may function usefully in time without artificial support. Or splints may provide permanent support for *treated* teeth where the existing periodontal structures will never be strong enough on their own. A

decision may have to be made in the latter case as to whether the remaining teeth are worth the considerable effort, expense and time of involved prosthetic procedures. Otherwise simple fixed or semi-fixed structures may be used.

Habits such as bruxism may often be treated by occlusal adjustment alone, but night (or bite) guards—acylic appliances covering the surfaces of the teeth or keeping the occlusal surfaces apart are usually constructed as well.

An attempt has been made here merely to outline the approach to non-surgical therapy and it has been emphasised that although in simple cases treatment may be complete, nevertheless this should be regarded as part of an overall plan which may involve surgery.

Acute conditions have not been considered here, because in relation to the conditions dealt with they are comparatively rare. Acute ulcerative gingivitis is treated in the main along the lines indicated here today by attention to local factors. There is encouragement from early reports that metronidazole shows some promise as being efficacious in dealing with the acute stage of the lesion.

CRISIS IN COMMUNICATION

Congresses, symposia, conferences, assemblies, meetings (and no doubt Roget could offer us many more) have become well-recognized phenomena of the twentieth century. All great melting pots for the production and consumption of mankind's most important and most eagerly sought-after food for growth—knowledge. Yet contrary to the present state of affairs in the world at large today, the production of this intellectual food is proceeding at a rate far exceeding the rate of increase of the population, so much so that when the population of the world is twice that of today the amount of knowledge will have increased eight-fold! The question is begged: "Will we end up dumping it in the sea, or will we find a way of dealing with it to our advantage?"

Medicine was a field in which this was inevitable. In his recent book* Sir Theodore Fox, ex-editor of the *Lancet,* told us that "The world now has nearly 6,000 (medical journals)—some say 9,000: it depends on the definition—and the number is still rising by two a week. Between them they produce some two million pages a year." But even in non?intellectual fields this "journalistic blastoma" is eating its way into our daily lives. Never before have so many novels dazzled the eyes of the entertainment-addicted masses. Weekly magazines vie with weekly newspapers, both growing progressively unwieldy, while the colour supplement has arrived to stay. Aha, do we see something sinister in that final move?

We have often been reminded of the concise impact of the illustration *vis-à-vis* the printed word, and it is possible that for economic reasons alone the printed word will give way to the work of artists and photographers. It is difficult, however, to see how the possible lines of evolution of mass media can be followed as adequately in the scientific field. It might have been possible when most of development of information was in the description of basic principles, but as the application and diversification from these roots grew, so did the subject become less definitive. While a drawing could summarize principles and facts, the stage was reached when less and less of our knowledge remained basic.

The biological sciences, with medince as their leader, moved rapidly into this state of affairs. Much of the energy and time being expanded in this field is taken up nowadays with the examination of the minutiae which might perhaps have something to add to knowledge which is often being applied nevertheless. Indeed

this last is probably the greatest consolation that can be obtained from the enormity of the situation. Take the example of chlorpromazine—since its introduction fifteen years ago there have been at least 13,000 papers published on the drug. Our knowledge is becoming increasingly statistical and paradoxical as it may seem in this age of science, empirical.

Sir Theodore's example of this situation is worthy of being quoted:

> "If one had been recording the resting blood-pressure of adolescents of a vegetarian Zulu tribe, all one can say is that after two hours' rest following a breakfast of mealies, at a temperature of 95-98°F., a humidity of around 85, and a height of 3,200 ft., the range of their recumbent diastolic pressure was 60 to 88mm. Hg. (mean 73); but the sample was not quite complete because fifteen of the boys had been frightened away by what the district officer said; others may have shown too high a pressure reading because they were scared by the witchdoctor's forebodings; four subjects had not in fact had breakfast, three because the cooking-pot had been upset in the night by a stray rhinoceros and one because of dysentery; and anyway the figures must be treated with reserve because the plastic tubing of one of the sphygmomanometers may have lost resilence in the long journey from the coast. Unfortunately, too, the tribe could not be regarded as living on a strictly goat-free diet because two goats had been eaten three days before to celebrate Mr. Kruschev's birthday . . . And when the data have been published in some way or other, we must still have a mechanism enabling Former Medical Officer, Laputaland, to throw doubt on the figures because (he tells us) the tribe investigated were not in fact pure Zulus but were originally an enclave of Scottish jute-workers who had inter-married with the local population."

Thus a crisis in communication how to organize the printed media in such a way that the doctor will obtain what he needs to know in the way of progress, in the time that he has available for reading. Obviously this time is too precious to be partly wasted poring through the many journals in search of material relevant to the particular field, apart from the fact that economic reasons will rapidly discourage this practice in those far removed from libraries. Sir Theodore suggested that the publishing of original papers in some form other than in the weekly medical journal is a partial answer, for he felt that the means of exchanging information were changing in the direction of personal communications; which is very likely as the fields of study are becoming in themselves so specialized with each expert knowing the others in the same field. This method of scientific communication was the rule of the seventeenth-century day.

A Plan for Inevitability

The future of medical journalism he saw as being divided between "The Medical Investigator's Weekly Monitor" for the research worker, a Clinician's Companion" and journals of associations, etc. All these are variations on the theme of the medical newspaper, at present one half of the mask displayed by the major medical journals. He saw the other role of medical recorder being of necessity lost to some other system of collection and organization for use of those who need it.

The most important generalization was that the medical journals and newspapers must return to the purpose of the continued *education* of their readers. Nothing need prevent the level of discussion from achieving a high level, but it must remain discussion—discussion on the results of the work of research workers, criticism, integration, interpretation, stimulation and amusement. It is the customer who must assume priority position number one, and the whole edifice of the journal existing, even if only in part, for the use of the writers (for the purpose of establishing priority or for helping the application for a junior registrarship) must be razed to the ground.

Reading is more than optics and registration; it is an art which includes the act of choice. Sir Theodore's editorial valediction itself has no doubt come under the scrutiny of some who have already developed this art and perhaps will now be read by others who have had enough time on their hands to read this review.

* *Crisis in Communication: The Function and Future of Medical Journals*, by Sir Theodore Fox, Athlone Press, 1965. Price 15s.

The Army offers good pay and good conditions to Doctors

You owe it to yourself to find out the facts about the Royal Army Medical Corps

The Royal Army Medical Corps offers Medical Cadetships to suitable students who have passed their second M.B. or equivalent examination. In addition to the payment of tuition fees and the provision of books and instruments while the student continues his studies, these Cadetships carry a probationary rank of Second Lieutenant with basic pay of £730 plus generous allowances for board and lodging to a total of over £1000 a year. On registration, Officers are promoted to Captain and, if married, would earn over £2,000 a year.

Service in the R.A.M.C. offers a great opportunity to the young doctor in whatever field his interest may lie—from practice in one of fifteen specialties to general practice, including the care of women and children.

Full details are contained in the booklet "A Career for Doctors in the Royal Army Medical Corps".

Write now for your copy to:-

Colonel A. D. Young, D.S.O., M.B., The Ministry of Defence (A.M.D. 2), Dept. 482 Lansdowne House, Berkeley Square, London, W.1.

GUY'S THROUGH AMERICAN EYES

by Thomas M. Buchanan

Seattle, U.S.A.

John Donne, 17th century poet-parson, has expressed his involvement with mankind as: "No man is an island, entire of itself, every man is a piece of a continent, a part of the main; if a clod be washed away by the sea, Europe is the less, as well as if a promontory were, as well as if a manor of thy friends or of thine own were; any man's death diminishes me, because I am involved in mankind, and therefore never send to know for whom the bell tolls; it tolls for thee."

In the spirit of poet-parson John Donne, and in keeping with the contemporary trend toward awareness of and involvement with the whole of mankind, let me make a few comments of comparison between English and American medical schools from my four months' visit to a prominent English medical school. Guy's Hospital Medical School is a school with great heritage and tradition. Built in 1724, under the sole financing of Thomas Guy, a merchant, in 1966 it presents an atmosphere at once antequarian, respectable and precious. During the mid-19th century, when Britain stood as leader of the world, Guy's Hospital was unsurpassed as a medical centre. Addison, Bright and Hodgkin were all instructors in medicine or pathology at Guy's then and the Guy's Hospital *Gazette*—the most widely read student medical publication, speaks with tales of a student vigour equal to any age. Addison also first described pernicious anaemia and another clinical medicine tutor of that era, Sir William Gull, first described myxoedema and anorexia nervosa. Samuel Wilkes, a pathologist of the era, was the first to describe alcoholic neuritis and malignant (bacterial) endocarditis. E. H. Starling, of Starlings law, Gowland Hopkins and Keats were all Guy's men.

I was in awe from the start when I realized I was "clerking" (pronounced "clarking") patients on Addison, Bright and William Gull wards, a very pleasant contrast from 4 east north or south, as the fashion for naming wards at the University Hospital in Seattle.

In the English Medical School there is only one Professor of Medicine and he is the equivalent of our Chief of Medicine. At Guy's he supervises year-round a "firm" which consists of all personnel,

including nursing students, qualified nurses, a "sister" (chief of nursing staff), medical students, house officers and registrars, attached to a ward—in his case William Gull ward of 40 beds. Other wards are jointly supervised by two consultants (year-round instead of two months as by our attendants) who are equivalent in rank to our professors. The professor and consultants at Guy's Hospital are masters at physical diagnosis and at absolute discretionary finesse in dealing with patients, emotions and attitude.

The pace at Guy's is slower than at the American medical school. The day begins for the students, instead of at 7.00-7.30 a.m., at about 8.45 a.m., and starts with laboratory investigations, which must be completed by the teaching session at 10.00 a.m. and ends at 6.00 p.m. And instead of every second to third night, there is no night duty for students unless they have a patient work-up to complete and except when they are on "take-in" emergency service for 3-4 days 2 to 4 times per medical term of three months. During this time the firm admits all medical patients to the hospital and is continuously on call. The students carry "bleeps" (bell-boys) for notification of emergency-room admissions, and there is considerable bedside teaching during this time. (Up to 5-6 hours per day by the senior registrar, who has had 4-7 years of post-qualifications training.) During the non-take-in periods, teaching averages 2¾ hours per day at Guy's and patient work-ups, laboratory investigations and daily progress notes must be completed in between the sessions.

In England the medical student is clinically given less responsibility in the total role of the hospital. Teaching sessions for students are directed solely at students and students do not attend hospital rounds. The English medical course is six years long (four years at Guy's) and the medical student is younger (qualifies at 23-24 instead of 25-26). The English medical student's atmosphere is less pressured. They have three major exams. throughout their course instead of 14. The competitive spirit was absent from the firm I was on at Guy's, roundsmanship was unheard of, and a greater percentage of time was spent in developing interpersonal relationships than in the U.S.

The average time spent in medical reading per day in England is 2-4 hours pre-clinical and 1-3 hours clinical; versus 5-6 hours pre-clinical, 3-4 hours clinical in the U.S. In four months in England I did not attend a single round in which a reference was requested or offered by British staff and students. Consultants' and registrars' opinions are, in general, accepted by students with little questioning. English medical students I viewed were as a mean as acute observers as American medical students, more loquacious in their conceptual descriptions, less frustrated, less competitive and less aggressive in their ambitions toward medicine. The medical students at Guy's have a building with recreational, T.V., common room and newspaper reading room and three-quarters of Guy's medical students read the London Times (or a comparable London newspaper) completely through five days out of the week.

Guy's has a pathological museum for which they have been offered two million dollars, which is one of the world's best. Readily observable pathologic specimens involving all aspects of medicine, are demonstrated in a large, three-storey, four-room complex where, among other specimens are displayed the original pathologic reports and specimens of the Bright's kidneys, the Addison's adrenals and the lymph modes from the first case of Hodgkins disease. Wax representations of skin disease are amazingly realistic and the entire museum is open for ultilization by interested students.

The financial hardships in British medicine increased since the beginning of the National Health Service are reflected at Guy's. Most hospitals in England are 50-100 years old and this is true also for the main medical building at Guy's. (Ref. (1) Discombe, G., The Organization of the N.H.S.: Progress and Problems, *Lancet* 1965, Nov. 13th, vol. 2, pp. 1001-9; and (2) Ross-Smith, C. J., Brit. N.H.S. Med. J. Australia 1966, Feb. 12th, vol. 1, 2 supplement, pp. 13-16). Guy's is more fortunate than most in that it has a new surgical block up to the standard of most modern American hospitals, which accommodates 600. It was able to build this by lending the government the money. However, many routine laboratory procedures for a University type hospital are unavailable at Guy's and often the unequivocably best laboratory or X-ray investigation method is unavailable due to lack of finance.

Nursing and paramedical staff in English hospitals have considerably more clinical responsibility and authority than in America. The medical student is responsible to the sister as well as the house officer, registrar and consultant. Nurses, physiotherapists and dietitians all take more individual initiative in their work. It is often the sister who handles the personal family-patient relations and most babies in England are delivered by midwives.

What can we as Americans learn from English medicine? Increased discretionary finesse in physician-patient relationships and increased delegation of authority to paramedical specialties. What can the English learn from American medicine? The open-mindedness and willingness to doubt opinion and greater enthusiasm toward the advancement of factual medical knowledge.

Guy's encourages increased student participation in the ever-enlarging international flux exchange of ideas.

REFERENCES.

See paper on Socialed Medicine, A Comparison of English, Swedish and U.S. Health Systems.

CORRESPONDENCE

The Late Doctor Conybeare

SIR—Whoever was responsible for one of the valedictory obituary reviews may, perhaps unwittingly, have caused grave offence in quoting his remarks on finding students praying in chapel. De Mortvis nil nisi bonis. It was not my privilege to know Doctor Conybeare well, but I am sure it was only gentle raillery at what he felt was a quirk of character, of which he had his own fair share, and it could best have been left unsaid.

We have our own view on these matters, and I recall how in my own young days when the lascars would get out their prayer mats on the forecastle of the old British India ships, I used to be deeply impressed—no callow students they, but grizzled old deck hands as tough as they come. Their religion was not mine, but this conviction that there is something bigger in life than themselves, shared by so many, is not without significance in our present day and age, and I would like to think this student practice still continues.

Yours, etc.,

ROBERT CUTLER

8, Lower Sloane Street,
S.W.1.

Cony

SIR,—It was with deep regret that my husband and I, like many hundreds of Guy's men and nurses, learnt of the death of Sir John Conybeare.

What happy memories we have of this generous, courageous man, of his kindness and great humility, and of his inimitable hospitality. His warm personality and his interest in, and love of, his fellow men, particularly the young whose company he so enjoyed, will long be remembered. Many an enjoyable evening have I spent on receiving the invitation "Come to dinner", and how happily the old and young mixed in his company.

I also remember the sounds of revelry which every now and then were carried across on the mid-night air to my bedroom at the back of Matron's House; yet another celebration, and how Sir John enjoyed their recurrent reunions and leave takings. I particularly remember his interest in the welfare of some of the elderly Guy's nurses, and his kindness in visiting them in their own homes; Sister Alice Park being one of his special favourites, and what an untiring visitor he was to all his sick friends and acquaintances when they were admitted to Guy's.

He also looked forward to seeing his old friend and colleague Miss Emily MacManus when she visited Guy's; what news they must have exchanged reminiscing about the past, and discussing the plans for the present and future of their beloved Guy's.

I shall always remember how thankful I was when as a third-year nurse I became familiar with his Textbook of Medicine, later to become "my bible", and what a sense of security it gave one in this field of medicine.

I do hope that the excellent photograph of Sir John, reproduced in the *Gazette*, will be given a prominent place in the precincts of the hospital; it is a joy to see the twinkle in his eye, and his relaxed, happy smile.

The sisters and nurses who have been privileged to care for Sir John in recent years at Christmas time will, I am sure, treasure the memories they have of him, and what Guy's meant to him. I hope the younger nurses will have been inspired by his devotion to Guy's, and that they will come to love and serve it as he did.

Yours, etc.,

JEAN RECKNELL

Chantry Green House,
Steyning, Sussex.

W. M. Mollison

SIR,—I would like to add a note to the obituary notice of my old teacher, who provided a link with Lord Lister in that he used to tell us that when carbolic sprays were introduced into Guy's Hospital by Sir Henry Howse, after using these sprays Mollison suffered from haematuria, not an uncommon symptom of those using this new method of antisepsis. It was "pestiforous", but obviously did no permanent damage to his kidneys.

Yours, etc.,

R. E. SMITH

Hill House,
In Rugby,
Warwickshire.

Failing and Shifting

SIR,—Miss Giles' letter made interesting reading as she expressed the reaction of the Nursing Staff at Guy's in the 1950's when a modified shift system was implimented and abandoned for the very same reasons she suggested, in that it gave a less satisfactory service to the patients, was unhelpful to doctors, and the nurses themselves felt deprived of the care and continuity of the patients progress. Less staff at some periods made the nurses tired. It is not only physical work which tires but the spiritual strength and personality put into nursing which is exhausting.

Taking all professions and trades, supply and demand would appear to stimulate changes, along with a sheep-like adhering to fashions and trends, with side issues of salaries and wages, condition of work, and social status, etc.

One wonders if enough investigation is made to estimate the value and over-all effects of such changes before they are implimented, or whether they are left to trial and error. It would seem that a long term and thorough investigation by Social Scientists would be helpful.

If conveyor belt work is boring, no one can say the same of nursing. While obviously all work and no play is undesirable, an eight hour day hurts no one and seemingly few have deeply delved into the reasons why less work per person is desirable. Is it to keep full employment? Time has proved this a misconception. Is it to obtain double pay for overtime—or to have two jobs, one in cash to avoid declaring Tax? Is it for more leisure?—but no one has really investigated what is done with so-called leisure. Too much of this and idleness, like too much cream, can produce revulsion. How many use their leisure to improve their education?

Incentive and great satisfaction can be found in work conscientiously carried out. Seemingly today, what is one person's gain is anothers loss, regardless.

Britain needs some logical thinking and a change of heart.

Yours, etc.,

M. S. GRIFFITH

"Moonrakers",
Mawgan Porth,
N. Cornwall.

Abortion Bill

SIR,—As expected, dismay and disapproval were registered when Passim recently published an article in favour of the Abortion Bill. Such reactions, however, only stimulate further thoughts and a consequent endorsement of what has already been written.

Despite his embryonic relationship with the medical profession, the writer feels he is able already to recognise and register a complaint against the disregard shown by the profession towards social reform. Let it be realised forthwith that the Medical Termination of Pregnancy Bill is a social reform bill. It is not a new legislation, for abortion is already in existence to the tune of 100,000 criminal attempts each year with, alas, the consequent high percentage of suffering and deaths. To allow such a state of affairs to exist unhindered is nothing but irresponsible, worsened only by hindering attempts at rectification.

On becoming a qualified medical practitioner certain social responsibilities are all too casually assumed and sometimes all too casually neglected (cf. Passim 4.2.67). The argument in question must surely constitute one of our most significant responsibilities to the public, one where procrastination and complacency can do nothing but harm, for it will not resolve itself.

Certainly we must not lose sight of the roots of this problem—better means of contraception and a higher level of social education—but until the *status quo* is re-established, an essentially negative reform is better than none at all. This is a perfect example of the end justifying the means.

Objections to the Bill are three-fold—legal, medical, and moral. To the medical profession the latter two are the most important. Medically it is feared that the Bill will lead to "abortion on demand". This possibility is well counteracted by the first section of the Bill which insists that abortion can only be lawful when two medical practitioners agree "in good faith" that theirs is a suitable case. As well, the Bill does not imply that the doctor need act against his conscience. It is purely permissive and should not make the consciencious objector feel he is passing the buck. It is also argued, on medical grounds, that an operation for termination is dangerous, even under legal, National Health conditions. Let it not be forgotten that, under any conditions, no operation is free from risk *and so on . . .*

Attempts to answer the moral objection resolve largely around the problem of definition. The arguments to decide when the embryo can be called a human being is somewhat nebulous. Is the legal definition of twenty-eight weeks, based on viability, a suitable one or should use be made of our increasing knowledge of sub-microscopic cellular elements? Surely the former is more acceptable? But if we cannot decide, the public certainly have, for they afford no respect to the spontaneously aborted foetus.

This is, of course, not the complete answer to the moral problem. Maybe such responsibility is too formidable to be rested on the doctor alone. It is for this reason that, if nothing else, the Bill does some good. It spreads the burden equally over the shoulders of both mother and doctor, neither under pressure.

Yours, etc.,

R. E. COWAN

The College, S.E.1.

A moo from Mona Heights

SIR,—The following idle ditty is all my own work (I hesitate to admit). Apart from Robert Browning that is.

Oh, to be in England
Now that Labour's there,
And whoever wakes in England
Feels, each morning, in the air,
That the lowest breeze from the credit squeeze,
Is to find your rewards are in tiny fees,
While the Beatles sing to the highest brow,
In England? How?

And after Labour, come Tory morrow,
When the City builds, and Country borrow!
Park, while the blooming exports in the red
Deepen to black and scatter in the clover,
Bossmen and new shops—on a Banker's pledge—
That's the new crush; he discs each song world over,
Lest you should prove he never could reparody
The first live careless rhapsody!
And though the field looks rough and makes us roam,
All will be better when the cows come home,
The brainy ones, the Little Country's power
—Far brighter than this Heath or Wilson shower!

Yours, etc.,

MICHAEL MABERLEY.

20, Aralia Drive,
Mona Heights, Kingston 6,
Jamaica, W.I.

Sembal Trust

SIR,—I should like to utilise your columns to express publicly the grateful acknowledgment of the Medical School to the Sembal Trust, whose Trustees have recently awarded the sum of £1,000 towards the cost of accommodation for a second electron microscope in the Department of Anatomy, for use by all those in this centre who require such means for their research. The Sembal Trust is closely allied to the Spastics Society, whose generosity has already been recorded, some years ago, in making the first electron microscope available to this School.

Yours sincerely,

ROGER WARWICK.

Anatomy Department,
Guy's Hospital Medical School,
London Bridge, S.E.1.

Sports Section Editorial

SIR,—Last summer an unfortunate incident, during one of the 1st XI's matches, prompted a rather thoughtless letter to the *Gazette*. A combination of rumours and further heated correspondence created a situation out of all proportion to the original incident. It should have been forgotten.

However, it would appear from last week's sports editorial that there are those among us who, in search of sensationalism, are ever ready to rake over the muck. Few members of this community could have liked what they read. In the past this section of the *Gazette* has, correctly, been devoted to summarising, exhorting, or congratulating the sporting achievements of the students at Guy's. To this end it serves an important role as sport has, and always will, occupy a certain proportion of most students' time at Guy's.

Fortunately, the question of racial prejudice in their sport does not. To pretend that it does, and to devote the whole of the sports editorial of the *Gazette* to it, is both inappropriate and misrepresentative.

In the past it has been obvious that a large number of outsiders read our *Gazette*. If their opinions are in any way influenced by the contents of such an editorial then every sportsman at Guy's, past and present, South African or otherwise, has reason to be ashamed.

I do not think there is any need for such self reproach. Personal experience of a fair amount of sport within the Hospital has never revealed any evidence of racial prejudice, or since it is more "easily pronounced" (sic)—apartheid.

What evidence has the Sports Editor concerning the political views of the South African sportsmen at this Hospital? What evidence, for that matter, has he of the attitude of the present Springbok cricketers? Perhaps some dressing-room eavesdropping may furnish more substantial information.

If one wishes to pontificate on such matters, the correspondence columns of our daily newspapers or "Speakers' Corner" provide regular and copious opportunity. Furthermore, the fortnightly resumé of our students' sporting achievements and gamesmanship would not be relegated to a mere "News in Brief".

Yours, etc.,

DONALD BARFORD

East Wing,
Guy's Hospital.

SIR,—I hope that the articles written by your Sports Editor in the last two editions of the *Gazette* do not reflect a new trend of reporting in this section.

I do not think that the sports section is the place for controversial political topics to be discussed. I would prefer a reversion to the old system, which has, over a number of years, given a valuable service to your readers, by giving a clear account of the Hospital's sporting activities that have taken place during the preceding fortnight.

Yours, etc.,

D. B. A. SILK

Sophies Hostel.

SIR,—The article on Apartheid and sport was inaccurate, contentious and irresponsible, and as such is hardly worthy of comment. However, one or two points need clarification.

You say that "within the hospital, Apartheid is an indiscretion"; I would draw your attention to the many letters published in the *Gazettes* of July 9th to October 1st which were frank and showed the many points of view on this subject. To suddenly print an article which is so biased, under sport and without signature is scurrilous.

In defence of Colin Cowdrey, I want to refer you to his letter in the *Sunday Times* of 19th February. This final paragraph, which was addressed to Michael Parkanson, would apply equally well to the author of your article—"it is an issue which you to your shame have seen fit to cloud with frivolous and mischievous abuse when so desperately it begs for constructive reasoning."

This letter is not written to question the principles involved, but to condemn the journalistic excess.

Yours, etc.,

ROBIN ELSDON-DEW

Tanglewood,
The Avenue,
Tadworth, Surrey.

Molly

SIR,—As a patient of the late Mr. W. M. Mollison, and as all my family also were, may I be allowed to say "What a perfect gentleman he always was", and this applies to all he did, in his work, at which he excelled. His kindness to us I shall always remember.

He will be greatly missed by his family, and, in this age of altering standards, he can ill be spared.

Yours, etc.,

(Mrs.) DOROTHY M. NEAME

Charnwood Cottage,
Charlton,
Shaftesbury, Dorset.

NURSING SECTION

What's in a white badge ?

The Members of the Nurses' Representative Council are asked many questions in this hospital about the work and format of the Council, perhaps the most frequent of which has been: "What is the Council and what does it do?", and a close runner-up for popularity is: "Why are you wearing a white badge with purple lettering and not a purple badge with white lettering?"

These questions occur with monotonous regularity, although the very fact that they are asked implies that there is public interest.

Since I feel that this information should be more widely known, I am giving answers to potential seekers after truth.

The Nurses Representative Council here is composed of 20 members, including a Secretary, Social Secretary, Psychiatric Male Nurse, Midwifery unit representative and a nurse elected annually from every set currently in training. This is slightly unusual, in that, in many other hospitals the body is composed purely of student nurses.

The Council meets formally every quarter with Matron in the Chair. The agenda is previously prepared at an informal meeting. A suggestion box is present in the Nurses Home, and nurses are free to put any suggestions for improvements

or matters relating to the well-being of the patients or nurses in this box. The appropriate set representatives can follow up each suggestion put to them by members of their set and investigate fully all aspects of the matter before it is put to the Council paper. The representatives are encouraged to consult the respective heads of departments on the practicability of each proposed change. This affords a valuable opportunity for nurses to meet hospital personnel in fields other than the nursing service, and to learn some rudiments of hospital administration, they also have the further opportunity of free discussion with the Matron. This is a great advantage, as at many other hospitals, the Matrons attend the meetings infrequently and only at invitation.

On receiving this information on the workings of the Council, a frequent sally is: "This all sounds very good, but do you ever actually acheive anything?"

The answer is strongly in the affirmative. Of necessity many of the problems discussed are of a domestic nature, such as the provision of increased uniform aprons for student nurses, suggested improvements in the planning of the patient's day, new sewing machines for the Nurses' Home, and even-softer toilet tissues for the patients! Obviously other matters brought up have more far-reaching consequences, for instance, recently the contents of the resuscitation trolley have been under discussion, as have requirements for promotion during the student nurses' training. Thanks to the Council's initiative emergency bells have been installed within all the treatment rooms of New Guy's House wards: Out Patients are handed an informative leaflet while awaiting their appointment—and a considerable amount of foil is collected for the organisation which provides Guide Dogs for the Blind.

As for the second most popular question received—all members of the Council wear white name badges instead of the customary purple, to distinguish them, as their work involves visiting the heads of various departments, and also so that the nursing staff can recognise their representatives.

Thus contrary to popular belief, the members are not a serene band of Vestal Virgins, discussing much, achieving little—a suggestion put forward by a member of the Medical staff, upon the institution of the said name badges.

The Secretary is invested with the seldom used power of making representations to the House Committee upon any matter of Hospital Management in which all the nurses are concerned and she has direct contact with the Board of Governors.

Once the minutes have been presented to the House Committee they are distributed to the various representatives who then circulate them to their sets. The minutes are also circulated to all Assistant Matrons, and to the Principal Tutor. The ward Sisters are fully informed of the contents.

Nurses representatives Councils where they exist in hospitals, and it must be remembered that all hospitals do not possess such a body, usually take a similar form, and it is hoped that their aims, achievements, vigour and strength are equal to those of the Council at Guy's.

Since we are fortunate to have such an active body I feel that it is perhaps a pity that it is not used more as a means of liason between the nurses and students, for both professional and social purposes. The Social Secretary would be pleased to help organise more student/nurse social functions, and many nurse professional problems could be thrashed out at a combined Nurses' Representative Council and Student Education Committee meeting.

It is hoped that this information will go some way to providing an answer to those who ask "Yes, but what is the Council and what does it do?"

S. M. BALDWIN
Secretary to Nurses' Representative Council

STAFF CHANGES AND APPOINTMENTS

DEPARTURES

Sister J. Morrison, from Relief Duties.
S/N H. M. Alexander, from Naaman Ward.
S/M G. Davidson, from Victoria Ward.
S/N M. Dennington, from Sarah Ward.
S/N M. Lambert, from Cornelius Ward.
S/N J. Morris, from Wilks Ward.
S/N J. M. Walling, from the School of Nursing

REVIEWS

A POCKET MEDICINE

by G. F. Beaumont, M.A., D.M.(Oxon.), F.R.C.P., D.P.H.(Lond.). Published by J. A. Churchill Ltd. Fifth Edition. *Price* 20s.

This book is directed at the student who has just arrived on the Medical wards. The author suggests that it should be carried in the pocket and read during odd moments; for example, while travelling in the 'bus or tube. This small book covers a great deal of ground so that all the common medical conditions, and a few unusual ones are mentioned. Each disease receives a short clinical account with an outline of treatment, including drug dosages. These descriptions of each disease are excellent thumb-nail sketches giving the important facts. However, one cannot help feeling that the student will have covered this ground, and in more detail, during the pre-clinical course. But some may find it a useful companion to gain an overall impression before referring to the bigger texts.

J. CRISP

COMMON DISEASES OF EAR, NOSE AND THROAT

by Philip Reading, M.S.(Lond.), F.R.C.S.(Eng.). Published by J. A. Churchill Ltd. Fourth edition. *Price* 30s.

The fourth edition of this book has been thoroughly brought up to date. In doing this the author has been faithful to his original aim to confine the scope of the book to *common* diseases. Hence, those conditions which were common when the book was first published in 1950, but which are now rarely seen, are accorded little space. Similarly, those diseases which have only recently emerged, or become recognised are given more attention. The text, whenever possible, associates the signs and symptoms of disease with any underlying alteration in structure or function. While only including the operative details of manoeuvres which the houseman may be expected to perform, it does lay stress on pre- and post-operative care. This book, with the aid of many illuminating diagrams, covers all the ground needed by the student or houseman, and can only be thoroughly recommended.

J. CRISP

HAND SURGERY.

Editor: J. Edward Glynn, M.D. Published by Williams & Wilkins Co., U.S.A. *Price* £14 0*s*. 0*d*.

This book is a massive work on all aspects of the surgery of the Hand. It is compiled under the editorship of J. Edward Flynn, of Boston. There are 58 contributors, many being great authorities on various aspects of hand surgery.

Mr. Patrick Clarkson contributes two articles:

One, a common problem: the management of traumatic finger tip amputations.

The second, extremely rare: the indications and technique of toe-hand transfers to replace lost digits.

The majority of the contributors are from the American continent, but in the main essentials the opinions of the two sides of the Atlantic seem to be in agreement; both sides of debateable issues are clear described. There are some rather notable omissions, mainly concerning operative techniques which often are not dealt with fully enough in a book of this size e.g. the methods of tendon suture are not fully described, and the usual criss-cross technique of Bunnell is not mentioned.

Generally the book is extremely well laid out and the articles clearly presented. This is an important reference work valuable to anyone who deals with surgery of the hand.

The cost appears to be excessive, even for an American produced book.

P. C. SHAW

SPORT

BOXING

Together the Boxing Club and the Rugby Club hold the coveted distinction of being the oldest Clubs of their sport in the world. Quite a formidable thought. Records have been produced of a meeting of Guy's A.B.C. dated 1878, referring to events of the previous season—convincing evidence of its existence in 1877. A history that has produced names such as Matt Wells, an ex-British Lightweight Champion and long-time trainer of Guy's Boxing Club, to become incorporated into the sanctimony of Guy's boxing.

It was as a memorial that W. M. Sheeran, himself an ex-Guy's boxer and later Light-middleweight Champion of S.E. Division, donated the Matt Wells Trophy in 1965. Contested twice before, this annual event with Lynn A.C. Novices had so far denied Guy's the privilege of possessing the Cup. But on February 21st with the memory of losing by three bouts to two in 1965, and four bouts to nil in 1966, Guy's successfully fought to attain the Trophy by two bouts to one (Eddie Chater being unfortunately unmatched).

W. Onyeama, Guy's Captain and full-blue, opened the tournament in a light-heavyweight contest and outpointed (with a unanimous decision) B. Mitchell of Lynn A.C. D. Lindridge, in his second fight for Guy's, survived a "count of 8" and unanimously outpointed McSweeny, a fighter with 30 club fights to his record. Lastly Sam March was unluckily defeated on a split decision. But the trophy had already been won.

This has followed quite a rewarding season. Earlier this month Guy's travelled to the Corn Exchange at Cambridge to be narrowly defeated three bouts to two by the University team. The Cambridge boxers had just completed a gruelling training programme in preparation for the 'Varsity Match with Oxford in the following week. Further, two members of Guy's Boxing Club (S. Marsh and B. Davidson) and a member of our affiliated club, Lynn Athletic, boxed under the University colours in a match between London and the Belsize A.B.C. Sam Marsh was drawn against Vreter Ikumsah of Ghana—a fighter who had trained at one time with the Ghanian National squad, under the tutelage of Roy Ankarah, the ex-British Empire Featherweight Champion. A gallant effort by Marsh ended in a split decision in favour of Ikumsah.

It is with such determination that the Boxing Club has survived for nearly a century with a mere handful of active members.

RUGBY

Congratulations again to C. W. Thorburn on his selection to play for the Barbarians in the Mobbs Memorial Match, and also for achieving a place in the British University Side to play in France at Easter. But honours as such are becoming perhaps familiar to Thorburn and it is with the selection of J. Ross, also for the British University side, that we are excitedly aroused.

The "A" XV, after two drawn matches in the Semi-final of the Hospitals' Cup, will play St. Thomas's yet again on Wednesday. Perhaps a more positive approach by Guy's may solve this apparent stalemate.

SOCCER

From the Semi-final of the Hospitals' Cup, Guy's have emerged victors over St. Thomas's.

DIARY

RUGBY

Mar. 4.—O. Alleynians. Home.
„ 11.—Nuneaton. Home.
„ 18.—Gloucester. Away.

FOOTBALL

Mar. 4.—Manor Sports. Home.
„ 8.—St. Mary's College. Away.
„ 15.—U.H. Cup Final.
„ 18.—Catford Strollers. Home.

HOCKEY

Mar. 4.—Tonbridge. Home.
„ 11.—Tunbridge Wells. Away.

WATER POLO

Mar. 7.—Battersea.
„ 14.—Queen Elizabeth College.

SOCCER

U.H. Cup Semi-final
GUY'S v. ST. THOMAS'S

At Cobham. Saturday, 25th February, 1967
Result: won 1—0

In conditions marred by a very strong blustery cross wind, St. Thomas's kicked off at Cobham. For the first few minutes nervousness, the wind, and the unaccustomed roar of fans made play a little tentative. However, Guy's settled quickly and started to apply pressure, forcing two corners. Slow crossing from the wings and poor finishing around the box prevented Guy's opening the scoring, although Lindridge and Elias came close. After a period of almost continuous Guy's pressure, a good move by St. Thomas's resulted in Carter, the Guy's goalkeeper, making a good save. The ball was swiftly moved out by a solid-looking Guy's defence, and McClure, running onto a through ball shot just over the bar. At this stage Guy's were very much on top, and looked bound to score, but their play became scrappy, as a tinge of desperation seemed to creep in. A welcome breather came when the referee lost his whistle, but he recovered it and the game proceeded. Just before half-time Lindridge had a shot touched onto the bar by the St. Thomas's goalkeeper, but the Guy's forwards couldn't get the ball into the net, and the teams changed ends without scoring.

Guy's started the second half, and immediately ran into trouble—the ball being cleared from the Guy's box after a dangerous looking muddle. The play then started to follow the pattern of the first half, with poor finishing being the downfall of the Guys forwards. For a time St. Thomas's looked dangerous, and Guy's looked desperate. Then a clearance from defence reached Elias, who pushed it forward to Jacobs, who ran forward and crossed it low and hard across the goal-mouth to Lindridge, who shot the ball into the net from an acute angle; a fine goal.

Encouraged by this, Guy's pressed more attacks, but St. Thomas's became desperate, and fought back hard. At this stage some amazing decisions by the referee made the task of the Guy's defence much harder. In the last five minutes St. Thomas's forced three corners, and Carter made some fine saves. The Guy's defence, with Poole playing a fine game, held out to the end, the game finishing in pouring rain.

Guy's: M. Carter; R. Davey, S. Watt-Smith; I. Nash, R. Lovell, S. Poole; D. Lindridge, D. Jacobs, I. McClure, E. Elias, R. Leeburn.

Guy's are now U.H. League Champions, and are in the final of the U.H. Cup. Your support is VITAL at the final. Please see notices for further details.

J. ALLEN

United Hospitals' League
GUY'S v. MIDDLESEX

At Sidcup
Result: won 3—2

Heading the league table only by the fact that they have played one more game than their rivals, London Hospital, Guy's faced their last but one league game with apprehension. With the possibility of winning the league depending on maximum points from these two games and the London dropping at least one, Guy's needed a win.

Despite last minute desperation and a mad dash for the train, Guy's arrived expecting to meet their eleventh man at Sidcup. However, they had to start with ten men due to suspected arson on their winger's car.

Play was very tight for the first ten minutes; the half-back lines containing any attempts at goal by the forwards. Guy's, now playing the 4-2-4 system, found themselves struggling with only three attackers. However, their link men really worked hard and play was even until the twentieth minute when a brilliant run by the Middlesex left-wing ended in a goal. Guy's were now facing the possibility of their third defeat since November. After only a few more minutes Guy's pulled level. A cross from Leeburn was pulled down by Lindridge who swerved round the centre-half, jinked past two more defenders, and pushed the ball past the 'keeper.

Watt-Smith was having a good game as "sweeper" centre-half—a position he has adapted to with great effect. His hard-tackling and running are a great asset in the Guy's defence.

Ten minutes before half-time, with Guy's doing most of the attacking, they were at last joined by Jacobs, who had hardly started to sweat before he pushed Guy's into the lead with a well-taken goal.

So at half-time Guy's were leading 2—1.

The second half saw Guy's struggling to get through a wall of Middlesex defenders. Several times Elias broke through but failed to find the net. On one of his runs he was tripped from behind and Guy's were given a penalty, which Lindridge scored to put Guy's further ahead.

The game seemed to be won, but Middlesex were not beaten. After a mistake in the Guy's defence they were given an easy goal, which Carter had no chance of saving. Carter has made a good impression on this team; his agility and courage have brought off some good saves. With only seconds to go Middlesex had an easy chance to equalise, but were robbed by Carter's quick covering after an earlier mistake.

D. LINDRIDGE

Guy's: M. Carter; R. Davey, I. Nash, S. Watt-Smith, S. Poole; R. Lovell, D. Lindridge; D. Jacobs, I. McClure, E. Elias, R. Leeburn.

RUGBY FOOTBALL

GUY'S v. EXETER

At H.O.P. Saturday, 25th February, 1967
Result: won 15—6

After a quarter of an hour of uninspired play by both sides, who seemed to be suffering from the early morning "blues" a penalty was awarded to Guy's on their ten-yard line. A short penalty was taken, producing an orthodox threequarter movement. Rowlands chipped on, recovered the ball, and passed out to Barford who was coming up on the outside. Barford took the ball the remaining ten yards and scored in the left-hand corner of the field. Elliott failed to find goal.

Shortly afterwards, after some general midfield play, Elliott kicked the ball on up the middle of the field, followed it up well along with Davies, who gathered the ball two yards from the Exeter line and took the ball over. The try was unfortunately disallowed by the referee who ruled Davies offside.

Exeter were by now playing well, being much quicker on the loose ball and picking up on Guy's mistakes. But two penalty kicks and one mark at goal by Exeter failed to gain any points.

From a line-out just inside the Guy's half, Exeter forged on towards Guy's line, giving rise to a set-scrum almost on Guy's line. Guy's took the heel but with a good push from Exeter taking the ball over the line, Narper, the Exeter scrum-half, scored by diving into Guy's back row. The try was unconverted.

Half-time score 3—3

Guy's kicked off in the second half and were soon awarded a penalty half-way in on the Exeter 25-yard line. Elliott kicked for goal and the score was 6—3.

Guy's play continued to sparkle. A loose ball was picked up mid-field and sent down the line, which had been joined by Elliott. Elliott made ground, passed out to Barford, who ran the remaining twenty yards, scoring his second try. It was not converted.

More fast and forceful play by Guy's produced a set scrum within the Exeter 25-yard line. Exeter heeled the ball and made a kick for touch. It was charged down by Thorburn, who ran on, recovered the ball and went over the line leaving Exeter somewhat dazed.

Twenty minutes into the second half, the ball went loose from a line-out on the half-way line. Cockburn picked up, ran on and passed outside to Voss who, with the speed of a winger, ran along by the touch-line, avoided the full-back and scored Guy's fourth try. Elliott was unlucky with his kick, the ball hitting the cross-bar.

With the end of the game drawing near, Exeter began to press again. A line-out near the Guy's line caused a clearing kick for touch. This was charged down by Exeter. Guy's fell on the ball but Exeter managed to carry the ball over Guy's line from the loose maul, giving them their second try, which was unconverted.

In spite of the dull weather, Guy's provided some entertaining and at times inspired play.

Guy's: D. R. Elliott; D. Barford, J. Price, B. J. Rowlands, R. J. Beacham; A. J. Scourfield, P. G. F. Swift; J. E. Davies, G. Voss, A. J. Kingdon, J. M. Cockburn, C. G. Neville, C. W. Thorburn (Capt.), H. C. Sharp, D. A. Curson.

G. P. BOOTH

HOCKEY

GUY'S v. SEVENOAKS

Away — Saturday, 25th February, 1967

Result: won 1—0

Against a moderate Sevenoaks team, Guy's recorded their first Saturday win for some weeks. The result is about the only satisfying fact to report about this game; the play itself was scrappy, with few co-ordinated movements.

Straight from the bully-off, Guy's swept on to the attack, and scored a good goal after only five minutes. This followed a rapid interchange of passes between the inside trio, with Cripps applying the finishing touch. Play after this gradually deteriorated. Fewer and fewer passes found their men, with the result that the hockey became very disjointed. Guy's failed to heed the lesson of the goal—the team in general tended to hold onto the ball too long instead of making the ball do the work; in effect, there was too much dribbling and too little quick passing.

For most of the second half Sevenoaks were on top territorially. Fortunately, their finishing was weak, and White, in goal, had few direct shots to save. So Guy's ran out winners by the only goal of an undistinguished match.

M. APPLEBY

Guy's: N. White; M. Vellacott, D. Crafts; R. Kendrick, J. Crafts, C. Pearson, D. Steer; H. McMichen, M. Appleby, S. Cripps, A. Godfrey.

GUY'S v. GORE COURT

Result: lost 0—3

In order to view this 3—0 defeat in its true perspective, one must realize that Gore Court have not lost a match for two seasons, and that they regularly win by a larger margin than this, for they have one of the strongest teams in Kent. With this in mind, the team put up a good performance. Indeed, at half-time there was still no score, although it must be admitted that early on the Guy's defence was under heavy pressure. Soon in the second half Appleby scored from a centre by Steer, but the goal was regrettably disallowed on account of "sticks" by the latter. Yet again fortune favoured Gore Court when a blatant kick preceding their first goal escaped unnoticed by the umpire. Now the home club emphasized their superiority with centre-half Ivan Clark, who has played for, and judging from the reports of the latest trial, may play again this year for England, intercepting clearances in almost any direction, setting up chance after chance for his forwards. However, heroic goal-keeping by White and some spirited breakaways by the Guy's forwards kept the tally down and the Gore Court defence alert.

This was, then, one of Guy's best performances of the season, and a defeat of 2—1, which is what the score would have been had luck not gone the other way, would have been a fairer result reflecting more the spirit of the game.

Guy's: N. White; M. Vellacott, D. Crafts; R. Kendrick, J. Crafts, C. Pearson; D. Steer, H. McMichen, M. Appleby, S. Cripps, A. Godfrey.

J. K. CRAFTS

SQUASH CLUB

Results

v. Baltic Exchange. Won 3—2.
v. Trinity College, Dublin. Lost 1—4.
v. Beaumont Union. Won 5—0.
1st Round Hosp. Cup v. U.C.H. Won 4—1.
v. Beckenham. Lost 1—4 (Cumberland Cup).
v. Imperial College. Won 4—1.
v. Middleton. Lost 0—5.
v. Eton Manor. Won 4—1 (Cumberland Cup).
v. I.C.I. Won 3—2 (Cumberland Cup).
v. Brighton. Won 5—0.
2nd Round Hosp. Cup v. The London. Won 4—0.

The results since Christmas, as can be seen from above, have been reasonably encouraging. In the Cumberland Cup, Beckenham are much the strongest side in our division, so losing to them was no disgrace, although we surrendered rather easily; and the victory over Eton Manor was satisfactory revenge for our loss to them before Christmas. It is possible to say that we are out of any danger of relegation: but almost certainly without hope of promotion.

We have been very pleased to return the hospitality of Brighton and Middleton who entertained us so well on our tour. We also had a most enjoyable fixture with Trinity College, Dublin; unfortunately we met them on

the first night of their tour, I suspect the result might have been reversed a few day's later.

In the Hospitals' Cup two rounds have been safely negotiated, and "Tommies" now stand between us and the final. I hope we will be able to break the Mary's v. "Tommies" monopoly of recent finals.

Hospitals' Cup team: J. H. Newman, E. P. Davis, J. R. Webb, A. A. G. Thomson, N. M. White.

E. P. DAVIS (Capt.)

LADIES' HOCKEY

The Ladies' Hockey had a very slow start this term. The first match was cancelled by Royal Holloway College as they had to play a cup match. The second match was also cancelled as we could not raise a full team—unfortunately it clashed with a United Hospitals' match against Oxford University 1st XI. The following played for U.H.: S. White, R. Thorburn, E. Hogwood and A. Collins. Oxford fielded a strong side and we played an energetic, fast game but still lost 1—5. St. Bartholomew's could not raise a team for our match on February 4th, so ten of us had a practice out at Chislehurst.

The Semi-finals of the U.H. Cup was played against Royal Free Hospital at Enfield on February 8th. Guy's lacked the spirit which helped us to win the previous round; the forward line was slow to take chances, and with the defence muddling we were disappointed to lose 1—2.

On February 11th we played an eight-a-side match against Charing Cross Hospital at Cobham; it was an enjoyable, friendly game and was won 2—1. The match against University College was cancelled as they had inter-departmental games. We played Royal Holloway College on February 18th at Englefield Green; they kindly lent us two players so that we could play nine-a-side, but we were beaten 3—1 by a team more skilled in team-work and stick-work.

The match against Royal Veterinary College, on February 22nd, was the first home match of the season and was a seven-a-side. Guy's showed a better sense of team work, and with the fact that we were the faster team we had a good win 4—0.

Our thanks go to the following members of the men's hockey teams for helping us by umpiring: Mike Knight, Tony Sutherland, Richard Kendrick.

A.P.C.

HOSPITAL INFORMATION

APPOINTMENTS VACANT

GUY'S HOSPITAL MEDICAL SCHOOL

Applications are invited for the post of **Junior Lecturer in Pharmacology.** Salary in the range £1,415—£1,775, plus £60 London Allowance, with superannuation. Forms of application are obtainable from the Dean, Guy's Hospital Medical School, London, S.E.1, and should be returned as soon as possible.

PASS LISTS

THE CHARTERED SOCIETY OF PHYSIOTHERAPY

February, 1967—Final Examinations

Miss Barnard, C. A.
Miss Brassington, D.
Miss Cramer, A.
Miss Evans, S. R.
Miss Holbard, J.
Miss Lankshear, V. S. L.
Miss Kutar, P.
Miss Modi, K.
Miss Tapper, J. P.

PAPERS BY GUY'S MEN

Anderson, D. J. and Matthews, B. An investigation into the reputed desensitizing effect of applying silver nitrate and strontium chloride to human dentine. *Arch. Oral. Biol.*, 1966, **11**, 1129.

Anderson, D. J. and others. Variations in the sensitivity to osmotic stimulation of human dentine. *Arch. Oral. Biol.*, 1967, **12**, 43.

Barkhan, P. Acute promyelocytic leukaemia. *Postgrad. Med. J.*, 1966, **42**, 788.

Batty Shaw, A. Historical exhibition from the Norfolk and Norwich Hospital. *Proc. R. Soc. Med.*, 1966, **59**, 1241.

Besterman, E. M. M. and others. The dangers of intermittent intravenous heparin therapy. *Postgrad. Med. J.*, 1966, **42**, 724.

Bishop, P. M. F. The endocrine basis of sexual abnormalities. *Practitioner*, 1967, **198**, 167.

Brain, R. H. F. Peptic strictures of the oesophagus associated with duodenal ulcer and operations for its relief. *Proc. R. Soc. Med.*, 1966, **59**, 929.

Brain, R. H. F. and Reading, P. V. Colon transplantation into the pharynx and cervical oesophagus. *Brit. J. Surg.*, 1966, **53**, 933.

Buckle, R. M. Studies in blood keto acids in vitamin deficiency. *Proc. R. Soc. Med.*, 1967, **60**, 48.

Calne, R. Y. Present state of renal transplantation. *Practitioner*, 1966, **197**, 627.

Calne, R. Y. and others. Further observations on renal transplants in man from cadaveric donors. *Brit. Med. J.*, 1966, **2**, 1345.

Cameron, J. S. Renal disease. III. *Brit. Med. J.*, 1966, **2**, 933.

Chamberlain, G. and Wadsworth, M. Too many words? *Med. Biol. Illus.*, 1966, **16**, 246.

Clarkson, P. W. and another. Contribution of plastic surgery to the treatment of obesity in *Modern Trends in Plastic Surgery*. Ed. Gibson, T., Butterworth, London, 1966.

Child, J. A., King, J., Newman, T. H. and Waterfield, R. L. A defraction method for measuring the average sizes and shapes of red blood-cells. *Lancet*, 1966, **2**, 1404.

French, J. M. and another. Ether-soluble porphyrins in bile, meconium and urine. A new appraisal by microscale counter-current analysis. *Clin. Sci.*, 1966, **31**, 337.

Gardner, P. A. Eye disorders in handicapped children. *Nurs. Mirror*, 1966, **122**, 359.

Goulding, R. Human exposure to organochlorine pesticides. *Proc. R. Soc. Med.*, 1967, **60**, 26.

Gower, D. B. A kinetic study of the *in vitro* metabolism of 4-14C-dehydroepi-androsterone by rat testis tissue. *Steroids*, 1966, **8**, 511.

Harvey, Y. W. Identity by teeth and the marking of dentures. *Brit. Dent. J.*, 1966, **121**, 334.

Hawkings, C. F. Speaking at meetings. *Med. Biol. Illus.*, 1966, **16**, 229.

Hayward, J. L. The presymptomatic diagnosis of breast cancer. *Proc. R. Soc. Med.*, 1966, **59**, 1204.

Hunt, J. N. and Price, T. M. L. Current therapeutics CCXXIX. Poldine and peptic ulcers. *Practitioner*, 1967, **198**, 156.

Killey, H. C. and others. The effects of implanting compact and cancellous inorganic bone into the long bones of rabbits. *Arch. Oral. Biol.*, 1966, **42**, 716.

Langman, M. J. S. and another. Relation of sub-acute combined degeneration of the cord to vitamin B_{12} deficiency. *Nature*, 1966, **212** 787.

Langman, M. J. S. and others. Plasma and salivary thiocyanate in gastric cancer. *Gut*, 1966, **7**, 549.

Lehner, T. and Sagebiel, R. W. Fine structural findings in recurrent oral ulceration. *Brit. Dent. J.*, 1966, **121**, 454.

Lorber, J. The long-term prognosis of generalised miliary tuberculosis in children. *Lancet*, 1966, **2**, 1447.

Lubran, Prof. M. Measurement of gastric acidity. *Lancet*, 1966, **2**, 1070.

McColl, I. The comparative anatomy and pathology of anal glands. *Ann Roy. Coll. Surg. Eng.*, 1967, **40**, 36.

Maizels, M. Exchanges across cell membranes. *Proc. R. Soc. Med.*, 1967, **60**, 81.

Meadow, S. R. Stomatocytosis. *Proc. R. Soc. Med.*, 1967, **60**, 13.

Mills, C. P. Acute sinusitis. *Practitioner*, 1966, **197**, 757.

O'Brien, M. D. and Veall, N. Effect of cyclandelate on cerebral cortex perfusion rates in cerebrovascular disease. *Lancet*, 1966, **2**, 729.

Pentney, B. H. Favourite prescriptions in general practice. *Practitioner*, 1967, **198**, 105.

Reading, P. Epistaxis. *Practitioner*, 1966, **197**, 785.

Redmond, A. P. and others. Relationship of onset of respiration to placental transfusion. *Lancet*, 1965, **1**, 283.

Redmond, A. P. and others. The nature of Ag/Ab complexes initiating wheal and flare allergic skin reactions in man. *Fed. Proc.*, 1965, **24**, 633.

Redmond, A. P. and another. Delayed hypersensitivity to penicillin in man. *J. Allergy*, 1966, **37**, 98.

Redmond, A. P. and others. Clinical detection of the potential allergic reactor by immunological tests. *J. Amer. Med. Ass.*, 1966, **196**, 679.

Redmond, A. P. and others. Immune responses of man to benzylpenicillin and penicillin allergy. *J. Clin. Invest.*, 1966, **45**, 1895.

Ross, D. N. and Somerville, J. Correction of pulmonary atresia with a homograft aortic valve. *Lancet*, 1966, **2**, 1446.

Turk, J. L. Cytology of induction of hypersensitivity. *Brit. Med. Bull.*, 1967, **23**, 3.

Wells, R. S. Generalized hyperkeratosis—? Ichthyosiform erythrodermia psoriasis. *Proc. R. Soc. Med.*, 1966, **59**, 977.

Wells, R. S. Bullous ichthyosiform erythrodermia. *Proc. R. Soc. Med.*, 1966, **59**, 976.

Wells, R. S. Anhydrotic ectodermal dysplasia. *Proc. R. Soc. Med.*, 1966, **59**, 975.

Wells, R. S. and others. Gene effects in carriers of anhydrotic ectodermal dysplasia. *J. Med. Genet.*, 1966, **3**, 169.

Youlton, L. J. F. and another. Effect of tiring the forearm muscles in different ways on venous blood, pH, Pco_2 and standard bicarbonate. *J. Physiol.*, 1966, **187**, 343.

PERSONAL

TO LET, near Abersoch, Caernarvonshire, North Wales. Secluded 16th century farmhouse, modernised. Sleeps six. Easter onwards, except August. Box No. 67/3.

DENTAL ASSISTANT, LONDON, S.E., wanted after Easter. Family practice including children. Time off for further study possible. Furnished flatlet available. ADD 3822.

CHANGES OF ADDRESS

Capt. I. C. Perry, M.B.B.S., R.A.M.C., 4, Seremban Close, O.M.Q., Middle Wallop, Nr. Stockbridge, Hants.

Sqdn.-Ldr. A. F. Tredre, Officers Mess, R.A.F. Muharraq, B.F.P.O. 63.

Mrs. A. F. Tredre, 8, Wolverley Court, High Street, Albrighton, Wolverhampton, Staffs.

BIRTHS

EDEN—On 11th January, 1967, to Peter and Susan (née Carter), at 28, College Street, Irthlingborough, Northants, a second son, Jeremy James.

FIRTH—On 5th November, 1966, to Jean (née Kubale) and Peter Firth, F.R.C.S., M.R.C.O.G., a daughter, Christine Jean, sister for Fiona and David.

REYNOLDS—On 16th November, 1966, to Annelies (née Fischer) and David, F.R.C.S., of Bickley, Kent, a daughter, Charlotte.

DEATH

MANNELL—Louisa Grace, A.R.R.C. On February 7th, peacefully and suddenly at Eden Lodge, Melvill Road, Falmouth, aged 83 years. Trained at Guy's Hospital School of Nursing, 1909—1912. Subsequently Sister in the Preliminary Training School, Ward Sister, Night Sister and Home Sister to 1923.

We would like to remind our readers that all copy for inclusion in the Gazette must be received eight days before the publication date.

Personal notices one shilling per word (Minimum £1. 1s. 0d.)
Birth, Marriage, Death and Change of Address notices are without charge to subscribers.
Non-subscribers will pay £1. 1s. 0d. for all notices other than Personal.

GUY'S HOSPITAL GAZETTE

EDITORS D. S. ROBINS and C. B. BROWN
SPORTS CORRESPONDENT J. G. PAYNE
NURSING CORRESPONDENT E. A. MALPAS

FORTNIGHTLY TWO SHILLINGS VOLUME 81 NUMBER 2052

The opinions expressed in these columns are solely those of their authors and are not to be taken as the views of the Hospital as a whole.

PASSIM

A Variety of Apples a Day

Well, for a start, Scientology under the N.H.S. is out.

A motley group of doubtful bedfellows thrive in a permissive environment. One of the outstanding features of this country has been its almost complete acceptance of the principle of free speech and thought. Result—Hyde Park Corner, an enormous Press and almost as many societies as there are people. Social life has been made infinitely more interesting by this and it has provided an opportunity for wearing an abundance of uniforms, with or without H.M's. permission, and ties that exceed Carnaby Street in their esoteric appeal.

The principle, note, is almost completely accepted. The brake is comfortably applied in the form "against the interests of the person/crown/myself" (delete as necessary). This multiple-choice proviso is the only level of difference; the names of Democracy, Totalitarianism, Communism are given to the rest merely according to the position of one's parents or schoolteachers. We are governed by the whims of an individual or two, sometimes disguised as a committee further disguised as representational. We are so obsessed with the position of our parents or school-teachers that we pinch our nostrils tightly together and deride roses by other names. Above all we forget the necessity of questioning our premises.

As large a field of combat as any pathological process in the attack of medicine against disease is that of ignorance on the part of the ill—an excusable ignorance one might say. While the profession binds itself by Declarations and the Hippocratic Oath (which somehow few newly-qualified seem to have read, let alone sworn) to control the ethics of its conduct towards this gullible public there is little evidence of similar restraint in the fringe medical organisations who pander to the cries of this ignorance. In spite of free medical aid, fortunes are spent on obtaining bones manipulated—either in the body or on the ground. Colons are irrigated while palms are read, minds are pseudopsychoanalyzed while bodies are massaged; fad and vegetarian diets, herbs, isometrics, hydro-therapy, and finally Lourdes for the faithful.

The list is far from complete. It has now been seen fit to effectively outlaw Scientology. The old multi-purpose clause has been invoked. Someone has decided democratically alone that this has gone too far. Similarly, the taking of a tablet, inhalation or injection in or soon after leaving a furtive meeting in a smoky discotheque has fallen under the pens and voices of disapproval and clamour of Press and Parliament. Both these are measures to interfere with the choice, however sad, or adjudged immature, of an individual who directly harms only himself. Yet little fuss or action has pursued, for example, the organisation which campaigns against vaccination and immunization, the results of which could be directly harmful to others. To say nothing of the daily and nightly far more prevalent consumption of alcohol throughout the country.

Where and when one must ask is there justification for invoking the all purpose clause? If the principle is truly democratic it must be independent of the moral indignant righteousness of the majority, or those who claim to speak for them. Whatever we may feel about charlatans or quacks, or as the case may be treatments more effective than medical science, we must decide sooner or later, preferably not the latter, whether we are to be truly democratic or are to admit to autocracy in such matters, and let this decision be a premise for our actions. And then, please, let us act!

For Passim's part, in the field of medical legislation variety leads to a life of spice, but with an indigestible sequel.

Our Tower of Babel

It was way back in the early thirties that the idea of expanding Guy's was first proposed and discussed. But like all proposals for major building operations the main obstacle which had first to be overcome was the acquisition of an appropriate site. In this particular case the best position would be adjacent to the hospital. But none was available at the time.

But then the War came and plans were temporarily shelved. The merciless bombing of London began. It was one such bombing mission that resulted in the destruction of the old East Wing and the adjacent neighbourhood. The Governors saw their chance and bought the site where New Guy's House and the car park in front now stands. The war, ironically, had provided grounds for expansion.

The War ended and a building in the shape of a giant star was decided upon, of which only a couple of the arms would first be built. But the National Health Service was introduced and the purse strings were pulled tighter. Furthermore, the Government was against the plan of a star since it would restrict further building to this master plan.

Nevertheless, a long, hard battle of obtaining approvals from the various authorities for a Surgical block began. Plans were drawn and redrawn, costs were calculated and tenders were put out culminating in the grand opening of New Guy's House by Queen Elizabeth in 1958. The dreams of many were beginning to see the light of day.

The first victory was acclaimed but there were still others to be fought for.

The concept of a Tower arose out of the restriction to build a large, massive block over the rest of the site. There was no other way of obtaining space but to go up. But there were other difficulties. The position of the Tower had to fit in with the line of Southwark Cathedral, and the local borough's approval obtained, as well as that of the G.L.C. and the Ministry of Health. The Tower also had to fit in with the projected plans of the out-patients department which will later form a large base to the tower incorporating a smaller block for the medical wards.

And so the whole process of drawing and redrawing, costing and estimating began again. The result of all the subtle manoeuvres will be completed by the early seventies—the Tower Block. It will contain the whole Dental School and its various departments, Paediatric, Obstetric and other departments, clinical investigation laboratories, and more besides. Thirty-two storeys high, a veritable Tower of Babel.

We offer our congratulations to Mr. Robert Hunt, J.P., of Torquay, on his appointment to the post of Chairman of the Representative Board of the B.D.A. Mr. Hunt qualified L.D.S., R.C.S. (Eng.) from Guy's in 1925.

It would appear that some of our readers and a number of quoters are still labouring under the misapprehension that the *Gazette* is the official hospital journal. From this issue onwards, therefore, we are printing a regular statement of denial. We would emphasize that this includes all sections of the *Gazette*, e.g. the Nursing Section is not the official opinion of Matron's Office, but that of the Nursing Correspondent or those individuals who write in it.

Gazettophiliacs will perhaps be glad to have their attention drawn to the fact that concealed in this issue is a 16-page pull-out containing the story, songs, criticism, the participation list and even a couple of photographs of the Residents' Play 1967—and all without extra cost, not even delivery charge. The colour supplement cannot be far away.

GUY'S DIARY

MARCH			Exhibition: BREAST CANCER (in Gordon Museum).
			Clinico-Pathological Meeting: There will be no meeting this month owing to Easter.
			Departmental Round: There will be no Departmental Round this month.
20th	M.	1.00	Clinical Lecture. Mr. BEARD. "Some Recent Cases".
30th	Th.	1.00	Clinical Lecture. Mr. WASS. "Enlarged Glands in the Neck".
31st	F.	1.00	Ciinical Lecture. Dr. KAUNTZE. "Carcinoma of the Bronchus".

WORDS

by Stewart Cameron

"Words are the footsteps of reason."—*Francis Bacon.*

"When I use a word," Humpty Dumpty said in rather a scornful tone, "it means just what I choose it to mean—neither more nor less."

* * * *

Most doctors become Humpty Dumpties not through malignancy but because of something that ought to be less forgivable—carelessness. This carelessness runs through their use of language in all situations, whether dealing with patients or colleagues, or in medical writing. Let us look at two of the words most commonly heard in the wards: "diagnosis" and "treatment".

When we use "diagnosis" it should be with a constantly present awareness of the many levels of meaning that diagnostic labels may possess. Even with this awareness there are some areas where the term can never apply. It is most frquently misused where "clinical presentation" would be more appropriate: no one ever diagnosed a syndrome: he observed it. We abuse this useful word "diagnosis" because it is convenient to do so. By blurring the edges we conceal from ourselves that we often don't have a diagnosis, even after doing all the right things. This results in a further misuse of terms for the temptation to talk as though we did know what is going on becomes overwhelming. I would plead for the use of "clinical presentation", "working diagnosis" and the American "in a setting of": this last term indicates an ignorance of the relation between component of a clinical picture and prompts further thought as to where it lies.

"Treatment" is even more shamefully abused. It is used for everything from specific remedies to the vaguest of general measures, without a scrap of evidence to support their use. The missing word here is, of course, "management", which includes both treatment and old-fashioned "care". Why do we persist in this error? Because it

is unpalatable to admit repeatedly that there are diseases for which there is no treatment. This misuse of language abets our little self-deception.

These two terms are misused partly for unconscious gain in security for doctor and patient. This is understandable, but unfortunately much abuse is more careless than this. As examples: *hemiplegia* and *hemiparesis, dysphasia* and *aphasia.* Even more serious is to ignore the difference between the two elementary components of clinical method: observation and deduction. The student is assailed with this as soon as he reaches the wards. "Diminished air entry" and "aortic and mitral areas" are two pieces of nonsense which depend on this error. As teachers we are careless in perpetuating nonsense terms quite uncritically. Consider the Central nervous system. The intelligent student may well expect this to be followed by the Peripheral nervous system, but he will wait three years in vain. Or think about the "standard urea clearance" which is neither standard nor a clearance.

Many of our ideas are so imprecise or inaccurate that they are useless, and exact definition of terms, although dull, is essential. Asher (1959) has pointed out the curious toughness of names which do not correspond to any facts, and how easy it is to ignore an obvious clinical fact until it is named. Terms have their own persistence so it becomes important how they are introduced. An overprecise name, which implies or states more than we know, is a handicap to understanding.

When using names it is important that we should understand the derivation of the words we use. This *should* bear on how we use them. Established terms are more difficult; in many instances knowledge of the derivation only confuses (for example—angina; haemosiderosis; epithelium; meconium). What is more important is an understanding of the *historical context of the term* (and anything over five years old has a habit of turning into history). The "nephrotic syndrome" is meaningless in itself unless the student has some idea of how notions about nephritis, and the words used to describe it, have evolved.

Criticism of medical writing has centred largely on style rather than on the content as outlined above. Bean (1962) has aptly christened this style "eunuchoid". Medical writing is said to be pompous, long-winded, ugly, flabby and dull. All this is true but, because it does not appear to matter immediately, doctors continue to write and talk this verbal garbage. Their papers get published, their colleagues and students appear to understand, so why bother with all this pedantic nonsense? And so everyone accepts that it is a shame doctors write so badly but then we're all so busy. And the idea becomes a member of that curious, lonely group which have become platitudes without ever influencing action.

In fact, this is a matter of desperate importance. George Orwell, one of our finest English essayists, wrote an article in 1946 on "Politics

and the English language". This was concerned with political ideas and the language in which they are expressed, but it is possible to read it through, substituting "medical" for "political" and supplying one's own examples from appropriate medical texts. (To finish with style, Orwell gives a brief list of rules which apply exactly to medical or any other writing. His own conversational style is so clear and direct that one scarcely thinks of him as a stylist.) He makes the vital point: ". . . if thought corrupts language, language also corrupts thought." ". . . slovenliness of our language makes it easier for us to have foolish thoughts. . . ." Orwell later carried the political implications of this to their logical conclusion in "1984", when the government was able to render certain areas of thoughts inaccessible because language no longer existed to express the ideas. Fanciful? On the contrary, it is happening in medicine now. How many students never understand mitral stenosis because of "*left* ventricular failure"? How many give up in disgust at the terminology of the white cell series? How many doctors do not understand the first thing about renal function because of the nonsensical urea clearance mentioned above? Ask ten doctors to define type II nephritis, Banti's syndrome, petit mal epilepsy or addiction.

The message for medicine is clear; to make any progress we must invent precise, new, flexible verbal tools and preserve the crispness of our existing vocabulary of ideas and words. If we don't then progress and communication may become impossible.

Conclusion:

Most doctors shamefully abuse language. This is not only unpleasant but dangerous because it impairs their ability to think clearly.

This little essay says nothing new. It is some measure of how perennial the problem is, that it should still be necessary to write about it. If you have read it you will certainly enjoy the following:—

ASHER, R. (1959). Making sense, *Lancet*, 2, **359**. Talking sense, *Lancet*, 2, **417**

These should be annual reading for all medical students (and teachers!).

BEAN, W. B. (1962). Tower of Babel, 1962. Arch. Int. Med., **110**, 375.

ORWELL, G. (1946) in " Inside the Whale and other Essays", Penguin Books, p. 143, London, 1962.

Obiter Dicta

Mr. Blackb—n: (fitting a disposable glove) "Why do they have to supply us with these diaphenous acromegalic prostheses?"

TEN LITTLE NIGGERS

by Agatha Christie

GUY'S HOSPITAL THEATRE CLUB

A Criticism

For their production this time the Theatre Club chose Agatha Christie's "Ten Little Niggers". It is debatable whether this was a wise choice; apart from the inherent weakness of the play itself, whereby the murderer at one stage appears to be himself murdered only to be resurrected later, two of the characters depicted are extremely old and it is difficult for any young amateur actor to play the part of an old person with any degree of conviction. On this occasion I think those called upon to play these parts did their tasks remarkably well, and Richard Chiswell as Sir Lawrence Wargrave is to be particularly congratulated, not so much for his voice as for his amazingly convincing gait and "pill-rolling" manner of his hands. The other "oldie", Stephen Orlands as General Mackenzie, was not so happy as he seemed uncertain whether to play the part as a cantankerous old army type or as a bumbling old fool, and usually fell halfway between the two.

Max Price as the nervous Dr. Armstrong was good when he was allowed to remain still on the stage. Too often, however, the producer had him moving around at high speed like a jet-propelled robot, which I found particularly disconcerting. Patricia Benson played the mealy-mouthed, narrow-minded spinster Emily Brent exceptionally well: so well in fact that I immediately felt my hackles rise every time she opened her mouth to speak. William Blore, played by Robert Tudor-Williams, was a strange hotch-potch. His accent was a mixture of Welsh, American and South African with a touch of Cockney, and his stance was that of a man who, having strained his back by weeding his garden, is now stretching himself.

What little romance the play permits was ably provided by Rosalind Knight as Vera Claythorne and David Graham as Philip Lombard. Rosalind Knight played her part of a secretary with poise and confidence and made one feel that if all secretaries were like that the bosses of the business world would soon be redundant (she was also very pleasing to the eye). David Graham is one of the best actors we have in the Hospital. He has a good, clear voice and a great deal of stage craft He moves naturally and does not try to force the character he is depicting beyond the bounds of that character. His Philip Lombard I thought excellent and I would like to congratulate him on his ability to lie in the position in which he fell on the stage after having been shot, without twitching a muscle for five or more minutes. His fellow-actors would do well to learn from him.

One felt that Bruce Wright was a trifle unhappy as Anthony Marston. He attempted to force the character where as he would have been better to play it in his own cheerful extrovert manner. This should have been a gift of a part as it calls for a rather wild, racy, motor car loving type of character and many a medical student plays this type every day in real life. Not all the blame, however, should be placed on the actor as lines such as "I say, Wizard", do not help. Could not the producer have changed these lines to some more modern idioms?

Andrew Blinkhorn as Rogers, and Frances Pratt as Mrs. Rogers were well played, although Andrew Blinkhorn should have shown more force when telling his whining wife to shut up. Christopher Winning brought a refreshing touch of Devon in his playing of the boatman Narracot. I have no idea whether the purists would have liked his Devonian accent but I found it convincing. I was especially pleased to see that he resisted the temptation to play the part as if Narracot was some oafish country bumpkin.

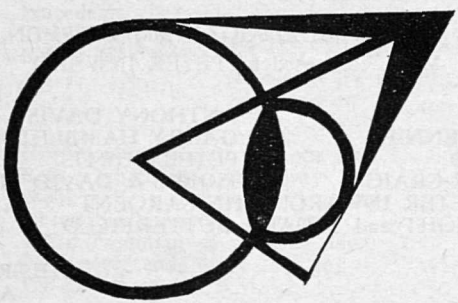
Peter Hunt, and all those responsible for designing, painting and erecting the scenery are to be congratulated: those concerned with the erection particularly so, as they had only forty-eight hours in which to remove the mess left by the Residents' Play and to bring their own labours to fruition.

Roger Davies handled his actors and actresses well and part from the minor criticisms already mentioned, showed himself to be an extremely able producer. To him, to the players and to all those others, too numerous to mention individually, but without whom the play would not have been, I send my thanks for a most enjoyable evening.

COLIN HUNTER-CRAIG.

THE RESIDENTS' PLAY 1967

DOCTOR YES



by

Ian McGill

CAST

in order of appearance

Dr. Moan (M)	GEOFFREY MACHIN
His Houseman	BRIAN McGUIRK
Dr. Scotch (000)	PHILIP RANSLEY
Mr. Blackbeard (00 No)	JOHN COLLINS
Mr. Giblets (004itis)	PETER BOWEN-SIMPKINS
Professor Sampson	JOHN SEARLE
Squeamy	COLIN SOUTAR
Sergeant Major Jerkins	PETER ASHCROFT
Dr. Hyphen-Bendall (Soft Job)	STUART BRAMWELL
Mao-Tron (Fussy Galore)	MICHAEL BRUMMITT
Professor Baloney	SIMON WOOD
Dr. Waste	PATRICK PIETRONI
Dr. Stafford Nark (Dr. Yes)	DAVID TONG
Porter	JOSE DE NOBREGA
Dr. Gauntze (Gold digit)	TIMOTHY PEET

Yes Men

JOHN POWELL-JACKSON — DAVID BYER
CHRISTOPHER PENNEY — HUGH STURZAKER

Physios

RICHARD SHARP — DAVID HENDRICK
RICHARD ROBINSON — MICHAEL FRENCH

And

MARTIN JOURDAN (nurse)

Produced by MICHAEL D'SOUZA and STEPHEN ROBINS

Music composed by PETER INWARD

Lyrics by

IAN McGILL — ANTHONY DAVIS
DRUMMOND RENNIE — GARRY HAMBLETON
PETER INWARD — PETER CURTIS
COLIN HUNTER-CRAIG — ISOBEL & DAVID MATHIAS

At the pianos: PETER INWARD, JOHN SARGENT
with JOHN WRIGHT and STUART BUTTERFIELD

Stage Manager	PETER DAVENPORT
Set Designer	ANDREW SEAL
Lighting	JOHN HARGRAVES
Sound	ROBIN MATTHEWS MICHAEL LOCKWOOD
Costumes	LYALL RIKARD-BELL HEATHER KERR KEZIA JOHNSON ELIZABETH RANSLEY
Properties	COLIN SOUTAR ROWARTH SPURRELL PETER TRENCHARD
Make-up	WENDY INWARD ELIZABETH RANSLEY ANTHEA BOULD KATRIN GANGUIN
Continuity	ISOBEL MATHIAS
House Manager	ROBIN STOTT
Recording	J. HOULGATE
Evening Dress	S. DA COSTA
Business Publicity and Programmes	DAVID MATHIAS & SIMON WOOD
Secretarial Help	JACQUELINE WILKINS ANNE OTHER

This year the play was witty, well performed and told a good story. Actually the review could end with that statement. Too often Residents' Play reviews are obliged to tie themselves in knots in order to praise mediocrity or make flat footed humour sound funnier than it is. This usually makes it sound leaden footed. 1967 was a year when this wasn't necessary.

. . . BUT IT'S TRUE **Opening Chorus**

We're here to introduce to you
Some characters all old, none new.
Before the next few hours are through
You should know the Consultants who
Basically are good chaps too
But in this play are shown for you
In our somewhat jaundiced view
—but it's true

We are sure that you will make a
Marvellous wife, Mrs. Baker,
We always knew that he would take her
The only shame is that they make a
Precedent. The rule that states a
Couple may not share will take a
Knock by Charles and Mrs. Baker
—but it's true

Now you've come to see our Play
Before we frighten you away
We'll make sure you hear our say
About the houseman of today,
Their discontent—a working day
That never ends or so they say
We all blame the B.M.A.
—but it's true

We are sure the Play's the thing,
The boys are here to act and sing.
We hope enjoyment they will bring
In our drama of doctors spying
On mutual empire building,
In new Guy's skyward towering.
Ambitions now are overpowering
—but it's true

The hope is ours that you enjoy
The play in ploy and counterploy,
The use of Fleming's horse of Troy
Bond without a sexy toy
Is the theme of author coy
To attack your image and destroy
The power and glory you enjoy
—but it's true

The Story

Act 1, *Scene* 1. Physicians' Room, Hunt's House. A bemused physician, Dr. Moan (M) ("Look, come in would you. Look who locked the door.") states his traditional case and is soon on the phone to a Royal Personage talking about an ailing Corgi (Addison's Disease yet!), and prescribes "Two potatoes baked in their jackets and half a glass of Madeira". This leads to Dr. Moan's song.

THE UNIVERSAL MANN **Dr. Moan**

My colleagues, though they're none too wise
Will each say what his skill is:
Guy B. has quite a name at Guy's
For shrewdly picking fillies.
But Super Mann in Ascot guise
Is prey to Super-Willies.

Whilst Peter Bishop flogs his glands
Our Heritage still lingers,
Charles Baker lulled by soothing bands
Of softly Swingling singers,
And Ronnie stroking Mongol hands
With faintly grubby fingers.

That cradle where my life began:
The School, Well, look, I mean,
With broad Homeric brow I scan
Hunt's damply swinging scene
Where every prospect's vile, save Mann,
And parts are quite obscene.

They've holed our antique, part-time ship,
Hosannas rock the air;
The "Thoughts of Hunt" on every lip
(But Wass' whose fag is there)
Competing for the right to strip
Our backs and cupboards bare.

My youth was spent in fits and starts
In Follies French and risqué;
I dabbled in the Occult Arts
And absinthe mixed with whisky.
I lived life through in all its parts,
And came through seared but frisky.

This saga which that verse began
I now end lest I bore you.
Judge not too harshly, if you can,
My failings, I implore you.
The child is father of the man
That Mann you see before you.

He is joined by Dr. Scotch (000) from Ascot, Mr. Blackbeard (00No) from the Park, and Mr. Giblets (004itis) from a late delivery, and for a millisecond your reviewer feared an outbreak of the endemic Residents' Play disease, i.e., men in grey suits talking endlessly. Instead, the author wrote in some good plot lines and jokes. He merges that Moan and Co. are facing the threat of a mysterious takeover by Dr. Stafford Nark (Dr. Yes), the psychiatrist and Telly Personality.

This announcement could only cue a song:

LICENSED TO KILL **(000, 00No, 004itis)**

From D floor down to A floor
Or from B floor up to C,
We're the men who've got the beds
We're the men who'll get the fee.
So, if you're feeling healthy or even
if you're ill,
Call us, we're double 0 agents and we're
licensed to kill.
Here's to the Drugs,
Here's to the Bugs,
And here's to the Paying Mugs.

000

From St. Moritz down to Plumstead,
Or from Chislehurst to Guy's,
I'm the man for Ascot's meeting,
I'm the man for wager's prize;
On the square I'm just a shadow of my nimble former self;
But the slalom is the thing if you're smoking out your health.
Here's to the fags,
Here's to the nags,
And here's to the cricket bags.

004itis

From Victoria down to Charlotte's,
Or from Putney up to Guy's,
I'm the man for second opinions
I'm the man for verdicts wise.
Call me in—I'm not the fellow if you didn't use your cap,
Though gum saline is the answer if you're losing all your sap.
Here's to the os,
Abnormal loss,
And here's to nature's boss.

00No

From Highgate down to Putney,
Or the College up to Guy's,
I'm the man for woody goitre,
I'm the man for popping eyes;
At the racquet I'm a wizard—I can con the leading set;
Miniskirts are simple answer if you ask me if I sweat.
Here's to the game,
Here's to the name,
And here's to any old flame.

From D floor down to A floor
Or from B floor up to C,
We're the men who've got the beds
We're the men who'll get the fee.
So if you're feeling healthy or even
if you're ill,
Call us, we're double 0 agents and we're
licensed to kill.

Here's to the Drugs,
Here's to the Bugs,
And here's to the Paying Mugs.

Ghoulish screams herald the entrance of Professor Sampson (a Forensic Pathologist) carrying his instruments in a coffin-shaped case (pretty touch). From this he displays his instruments—

(Very funny this—my favourite was the modified peak flow meter—"when you blow into it it produces an ultrasonic wave, which renders anything in its path quite-er-deaf")—cuts his technician's hand off, all the while delivering a characteristically urbane monologue leading to—

A MORBID SONG **Sampson**

My manner is suave but my language is legal,
I do my p.ms'. in a way that is regal.
The way that I cut would make angels sing,
For know always this that I am the King.

This poor girl was raped and then was aborted,
And this is the way that young love is thwarted.
In matters like these I have the last fling,
For know always this that I am the King.

This boy was assaulted and cut into bits,
I put them together so that every piece fits.
It's cases like this that honour will bring,
For know always this that I am the King.

This man hanged himself but then was cut down
And pushed in a well and left there to drown
This isn't the verdict a Coroner would bring,
But know always this that I am the King.

I work in the morgue, the sights there are seamy;
It isn't the place for those that are Squeamy.
It's there that the best of my thoughts do take wing,
For know always this that I am the King.

I cut up the bodies, I don't need permission,
I check all the organs; see that nothing is Missen.
With my eagle eyes I don't miss a thing,
For know always this that I am the King.

Doctor and lawyer, I've nothing to fear,
I've a foot in both Camps so don't shed a Teare.
Through courts in the land you will hear my voice ring,
For know always this that I am the King.

This more or less ends the scene with the goodies identified and the villains about to be revealed in

Scene 2. Shepherd's House Gymnasium. This scene opens with a very butch crowd of singing/dancing physiotherapists. Their song :

SHEPHERDS HOUSE BLUES **Physios**

We're overweight Jane Russells wearing size nine shoes,
We've got advance emancipationist views.
You'd think we would be happy in our whites and blues,
But there is one improvement that we'd not refuse:
We've got a lot of muscles that we'd like to lose,
So we're just beefy amazonians singing Shepherds House Blues.

We go to work at nine, we leave again at five,
In a nunnery, resembling a dive;
And when we've served our sentence in this female hive
There's only one conclusion that you can derive,
That if we can't get men to buy us fags and booze
We'll be just lonely amazonians singing Shepherds House Blues.

We're oversexed Liz Taylors strictly conformist,
We sit in the park, but we're usually missed.
We'd like the Hampstead soiree with the Binge on top
But we're just lonely amazonians in a tomboy rock.
We'll take anything in trousers—what have we to lose?
Then we can say goodbye to the Shepherds House Blues.

They are dismissed by Sgt.-Major Jerkins and Dr. Hyphen-Bendall (Soft Job) enters. Soon he is joined by Mao-Tron (Fussy Galore), "the housemen do so interfere with the nursing, if it wasn't for them we could have a twenty-hour week now!" Further discussion suggests the possibility of a forty-hour week for patients, their very own shift system, and one which Soft Job has practised for years. Fussy's attitude is explained in a feverish song reminiscent of Peggy Lee.

MAO-TRON SONG **Mao-tron**

When I was asked to work at Guy's
For reasons best kept secret,
I had to leave my horse behind
But now I think I need it.
The saddle is all,
Come rise or fall,
Probably the latter.

I've tried to make this grand old place
Like one big happy family;
Instead it's chaos all the time,
It's really more like Bexley.
The rule is all,
Come rise or fall,
Probably the latter.

I try to keep in touch with all
But days go by so quickly;
The nurses' make-up troubles me,
No time to see the sickly.
The office is all,
Come rise or fall,
Probably the latter.

The shortage of trained staff I rue,
It's really quite alarming;
The nurses leave here all the time
Although I am so charming.
The blues are all,
Come rise or fall,
Probably the latter.

My uniform is deepest blue.
It fits me very nicely;
The hem two inches from the knee,
Let no one take it off me.
The dress is all,
Come rise or fall,
Preferably the latter.

It seems so long since I came here,
But yet my rule's just started;
Whatever you anticipate
From Guy's I'll not be parted.
I am all,
Come rise or fall,
You'll never see the latter.

is followed by the arrival of Professor Baloney, plus Dr. Waste—a Radiotherapist. Baloney is soon chatting up the Mao-Tron but is silenced by the arrival of Dr. Stafford Nark (Dr. Yes) and his four Yes-men. A good entrance this. Red carpet rolled out. Shining, hopeful faces of the four.

Dr. Yes outlines his plans to his followers—simple but effective. Radioactivate Hunt's House unless £500,000 is handed over—cash.

The friends are rhapsodising over the possibilities of what to do with the loot when Dr. Scotch (000) is revealed eaves-dropping. He is neatly disposed of by Dr. Yes who hypnotises him—"you are watching one of my television programmes".

EGO, EGO, EGO **Dr. Yes**

Glorious things of me are spoken
Most of them not fit for verse;
You with psyches that are broken
Must not think me too perverse.
Schizophrenics and depressives
Gather round and hear my song,
Freud and Jung spent years in writing
Things I've known of all along.

Paranoia and delusions
Are to me part of life;
Ego, Id and all obsessions
Contribute towards the strife.
We must have them to be normal
Moderation must preside,
Deviate from straight and narrow
And you'll find yourself inside.

Psychoanalytically
We find things take far too long;
I prefer the swift and easy,
Leucotomy's for a song.
Have no fear of your repressions,
We treat this every day:
Abreaction and hypnosis
Are to me a form of play.

In my view it is essential
Registrars must do the work;
Thoughts of mine are elemental
Humdrum duties I will shirk.
Literary works of genius.
Textbooks, pamphlets are my bent:
Now at last the world must realise
What I think Freud thought he meant.

Now the future lies before us
Progress in psychiatry;
Psycho-spacial nuclear fission
Is the life for those like me.
In the meantime I'm the saviour
Through the medium of T.V.
All disorders of behaviour
Can at last be cured by ME.

and Dance

All exit save Baloney and Fussy Galore, who is weakening under his burning gaze (she: "you're putting me in an awkward position." He: "This is what we call translocation") as the curtain falls.

Act 2. *Scene* 1. The Colonnade.

The Housemen, Nurses' and Physiotherapists' Song opens the action:

ROUND THE COLONNADE **Chorus**

If you want to hear the latest news
You must come and ask our views,
We hear all scandal as it's made
And embellish it if it fades:
It's part of our job to spread Guy's news.

The Christmas show did not appear
Let all present shed a tear.
Was last year's show far too blue
For those who wear that colour too?
We shall make sure it's there next year.

Matron might have banned this play
With permission of Sister Day,
It would prove a dangerous move,
No Consultant would approve,
They can take it anyway.

Patrick Tatford's won a prize
For an Army exercise,
But why Professor H.J.B.
Wasn't knighted we can't see;
He's still the same though in our eyes.

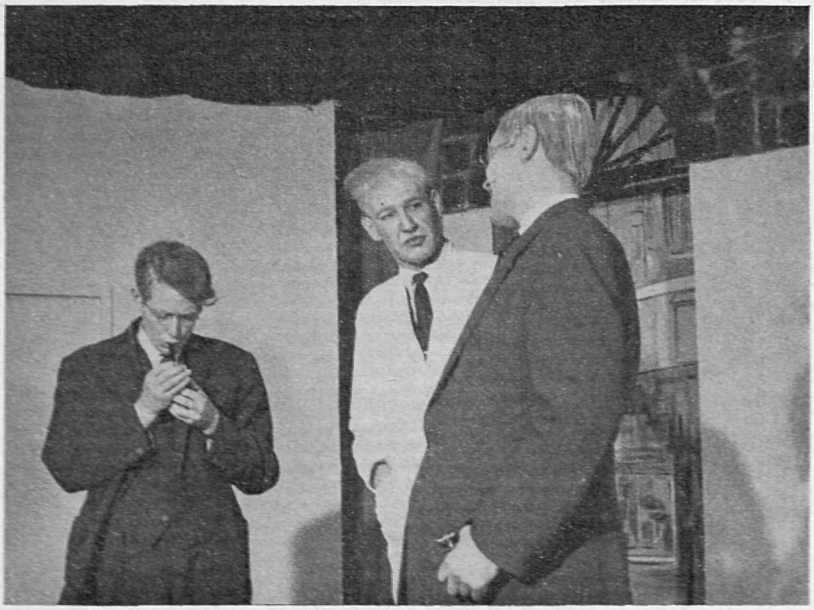
House jobs were increased in number,
But it leaves us all to wonder
As they're only six months long
Can our yearly play go on
Or are they trying to push it under?

Bobby Cann was locum Super,
Where was Sam, the trusty trooper?
Now Pip Helliwell's got the post
We thought J.B. was the most
Super duper of these snoopers.

Mr. Gibberd's run his term
And Nils Eckhoff leaves his firm;
We understand that Lolly's left
But of him we're not bereft.
He's underneath our epiderm.

The empty Tower Block is to rise
To a vast impressive size;
Kenneth Robinson's Red Cross parcel,
A great white Elephant and Castle,
A rather hollow joke on Guy's.

If you want to hear the latest news,
You must come and ask our views,
We hear all scandal as it's made
And embellish it if it fades,
We've finished our job to spread Guy's news.



Leaving 00No (Blackbeard) on the stage peering up the audience's mini-skirts with his cystoscope ("I think I'll do my next clinical lecture on the anatomy of the thigh.")
The good 00's have been called to meet Dr. Moan, who cannot find 000 (remember he was hypnotised at end of Act 1).

Consternation all round and a slight sagging of the action at this juncture till the arrival of Dr. Yes' demand for £500,000 ransom. Another Funny Story (—pay-off "God thinks he's director of the York Clinic".)

The sound of the word money cues the entrance of Dr. Gauntze. He offers them all fiscal advice, some bonds he happens to have on him, and sings his song:

GAUNTZE'S SONG OR GUINEAS ARE GOOD FOR YOU **Gold Digit**

Ralph is my name, I'm outstandingly charming
Hearts are my game—and a little bit of farming.
I've always worked in a rewarding field,
I reap what I sow and I get a good yield.

Not much good at murmurs, isn't that a pity,
But I can hear the rumours that circulate the City.
There is one murmur that I've got taped,
It's heard near the wallet and it's diamond shaped.

The first sound I hear is my secretary ringing,
The second sound I hear is the money-till dinging.
The door opens, snap, the patient is there,
For that's how it goes in Montague Square.

Credit is tight but I'm not bilking.
My cows are all right—it's the Revenue I'm milking.
For the only thing in life that's free
Is not the N.H.S. but the Masonry.

When I was up North I hadn't got a tanner
So I sallied forth to Blewberry Manor.
There was room at the top in Oldham, Lancs.,
But I preferred London; it's got bigger banks.

Please don't depart with an incorrect impression
You'll find my heart is in my profession.
There's more in life than shillings in the banks,
So hurry up de Gaulle, and let's get at those francs.

All exit as Hyphen-Bendall and Fussy Galore enter (why?)—answer so that Hyphen-Bendall can tell of the impending showdown. But he is softened by Sampson's offer (how did he get on to the stage?) of an outcome that could be professorial rather than morbid if he were to aid in the release of 000. Does he accept the offer?

BENDALL'S SONG

I know that I'm rich and handsome,
I am the athletic type.
And I owe it to testosterone—
An injection every night.
Be assured that my department,
Is the swinging place in town
Though my girls may not be Bunnies
Their massage is renowned.

I can tell you I'm not harassed
By my many To's and Fro's
For I've found if I leave them for a month
That the patient always goes.
Deep heat is the big attraction
For the ladies on the shelf
And when the young ones want the action
I try to give it myself.

See me now in Nuffield Theatres
With my braces bright and red.
I always cut a figure
That's well above their head.
All the drug firms love me dearly
For the clinical trials that I do
If they pay me, I'll show clearly
That all their claims are true.

My virile bedside manner
Makes my patients feel quite great;
If my colleagues get too jealous
Then my bowler seals their fate.
Dr. Yes will rue the day
That he ever trusted me
For now I've made a great decision
A double 0 gent I will be.

Scene 2. In the Directors' Room, the York Clinic, we get Baloney and Fussy Galore for openers and what openers. They arrive rather breathlessly for the showdown and continue their amorous operatic overtures.

RECIT **Baloney**

Bella, bella Fussy Galore. You are to me a paragon of beauty. For you the topless towers of Ilium would once more be set ablaze and ships launched forth to seek you. Come to me, and nestle in my breast.
Oh bella Fussy Galore.

DUET **Mao-tron and Baloney**

Tu se per me
Una grande amoré
Tu se per me
Cara Bambina.

Dai me un bacio
Bacio del fuoco
Dai me un bacio
Un bacio doice.

Sensa te
Io sono niente
Ma con te
Sono il monde.

was a Residents' Play Occasion when the show stops and the audience cheers its head off. I did.

Soon the villains are assembled—Waste dreamily talking of his future plans—"I have built a machine so complex that even my registrars can't see what it's purpose is."

The Triumphant Dr. Yes arrives to Wagnerian Music, rallies his henchmen

WE'VE WON **Baloney, Waste, Fussy Galore and Dr. Yes**

Chorus

Everything has gone as we had planned
The end is surely close at hand
What we have had to do is done
And now its clear that we have won
Yes! We've won! The Victory's ours!

Baloney

Alone I did it! I've won! It's me!
I didn't need the other three!
In spite of my exterior
I'm genetically superior
My parents didn't have the means
To dominate my receding genes.
Everything has gone. . . .

Waste

Alone I did it! I've won! It's me!
I didn't need the other three!
I'm frightened by the smallest thing
And I'd really rather not have to sing.
Everything has gone. . . .

Fussy Galore

Alone I did it! I've won! It's me!
I didn't need the other three!
As I gaze out at Lord Nuffield,
The House Committee try not to yield
To a Board of Governors with a Chairlady:
The suffragettes had nothing on me.
Everything has gone. . . .

Dr. Yes

Alone I did it! I've won! It's me!
I didn't need the other three!
They all say it, for me it's true;
"Your place's really too small for you,"
Said Lord Robens as he offered me
Guy's and Tommy's and the N.C.B.
Everything has gone. . . .

and, having passed the time unveiling himself and dictating a letter, he receives the crestfallen Dr. Moan, Mr. Blackbeard, Mr. Giblets and Dr. Gauntze. They hand over the money expecting the kidnapped Dr. Scotch (000) in return. Dr. Yes refuses. Horrors. "Do you think we'd part with our trump card?" The fiendish machine is prepared and its awful, and the audience is biting its nails.

WHO WILL STOP THIS FIENDISH PLOT? WHO WILL SAVE HUNT'S HOUSE AND NEW GUY'S HOUSE FROM 100 YEARS' RADIOACTIVITY? WHO CAN SAVE OUR HEROES FROM DISASTER? Holy finger cots! It's Batman and Robin. All cheer the dynamic duo. POW! OOOFF! ZOWIE! SPLATT! Their silent fisticuffs soon deal with the Yes Men, and as they unmask themselves as 000 and Soft Job the other evil doers all faint. M's men congratulate themselves, and Sampson arrives with Squeamy to clear up the mess.

The Final Chorus is sung and another residents' play is over.

THROUGH THE LOOKING GLASS **The Cast**

The Play is now over, the Goodies have won,
By traditions of old the Pantomime's run,
But this is the moment to seriously think
Of the Guy's of the future: does it swim or sink?
When we all came here young men so keen
It was following the light of men that had been
Famous physicians; Wilks, Gull and Bright,
But who is it now that carries the light?
Emigration, emigration, will it solve the situation.

Our famous old name still keeps some coming,
And because of these people we are still running,
But could they find out before they arrive
This poor old place would hardly survive.
A hospital living needs progress each day
If its good reputation is going to stay,
And the problem with us in this poor position
Is the hand on the helm—The Merchant Physician.
Emigration, emigration, will it solve the situation.

If you look all around you a feeling is growing
That what we are taught here isn't worth knowing.
The Merchant Physicians who teach us the facts
Of the practice of Medicine can quietly relax,
Safe in the knowledge that they hold the power
To keep academics out of the Tower.
So, providing they keep together and strong,
Our battle for truth will be hard and long.
Emigration, emigration, will it solve the situation.

The teaching at present by Jack of all Trades
Produces young doctors whose knowledge soon fades
Unless their affection is quickly transferred
To some other place where brains are preferred.
We have the potential so let us all give
To make the next years the ones that will live
So when the time comes, proudly we'll say,
Guy's is for ever—we made it that way.
Emigration, emigration, cannot solve the situation.

Rule Britannia 'twas never meant to be
Guy's rebirth is what we mean to see.

So much for the story. Now for the performances. Uniformity of excellence is hard to criticise but I have to mention Blackbeard (style), Baloney (panache) and Fussy Galore (very good female impersonation with echoes of Danny La Rue).

The songs were tuneful and well sung, again certain ones stood out. I think the Baloney/Galore duet will be long remembered by Residents' Play Collectors and I liked Gauntze throwaway number.

The script was clever, pointed and witty. The production crisp and professional. Altogether a pleasure to review. May I come again?

J.H.W.

Additional notes: J.S.G.

REVIEWS

VERTEBRATE BIOCHEMISTRY, Second Edition.

by M. W. Neil. Published by Pitman Medical Publishing Company Ltd. *Price* 45*s*.

The introduction to all textbooks paints a glowing picture of the contents as one might expect, and this book is by no means an exception. " . . . fundamental principles of biochemistry . . . a stimulating, accurate and cheerful exposition . . . " Unfortunately, as far as this book is concerned, their statements are far from accurate.

This book deals with the field of medical biochemistry in the usual way, relating most of its statements to medical phenomena and laying more stress on the biochemistry of the alimentary canal and the blood than on the chemistry of lipids, but throughout its chapters the same criticism can be noted over and over again.

General description is poor, for enzymes, proteins, protein synthesis, D.N.A., and haemoglobin to name but a few. The situation is not aided by a lack of diagrams. The tricarboxylic acid cycle and the urea cycle are blatant examples of circumstances where one simple diagram would be worth pages of description, yet no diagrams are given.

We are told in the preface that the text of this edition has been altered in the light of recent advances on the biochemical front, and yet some of the ideas and theories which are put forward are so antiquated that they have now passed into biochemical history. There is no indication of the modern ideas of enzyne structure and function and the vital importance of these ideas in understanding hereditory disease. The author also seems to be bogged down by the new ideas surrounding the functions of sub-cellular particles.

Localisation of particular pathways within certain sub-cellular components is a subject which is expanding at such a rate that it is now imperative to know not only how a reaction occurs but where, in order to correlate this with the inter-related reactions. Although a section is included on metabolic inter-relations, the author still leaves us with a picture of a cell like a witches cauldron, and little localisation of function within the cell is elucidated.

Overall this is not a book that I would recommend. It is too old fashioned in its treatment of most subjects and does not explain basic metabolic pathways in a very clear manner. Many statements, if not completely wrong, are confusing and explanations are so inadequate as not to be worth the space allotted to them. The whole book gives the idea of trying to compress a lot into a small space without, in fact, giving very much information at all.

J. O. SOUL

PHYSICIAN'S HANDBOOK.

14th Edition, Blackwell. By Marcus A. Krupp, Norman J. Sweet, Ernest Jarvetz and Edward G. Biglieri.

Any book that runs to fourteen editions can perhaps afford to cock-a-hoop at most adverse reviewers. And this information-packed vademecum is in the main so good that criticisms of it appear somewhat petty.

Designed as an ultra-quick reference book to refresh and reassure the memory of the reader of all the main diagnostic and therapeutic facts in clinical medicine, coupled with being a diagrammatic guide manual to most of the simple medical procedures, it is a truly ambitious undertaking. Yet it still manages to live up to its title of being "a handbook", for its overall dimensions remain only 7in. by 4in. by 1in.

Produced for largely American consumption, much of the spelling is not English and some of the trade named drugs are not immediately familiar. These, however, are minor irritations and by and large the book can be wholeheartedly recommended.

M.M.

CORRESPONDENCE

Cony

SIR,—After reading the cold, stereotyped obituary notice of Cony in the B.M.J. of January 14th, I was pleased to read the very deservedly warm and delightful tributes to my old friend in the Guy's *Gazette,* by some of his many friends, whose identity could not remember, or perhaps never knew.

Although an intimate friend of this unique, kindly, generous and lovable character for 47 years, I will not add any more stories or anecdotes to those of your correspondents (O.S.C., N.E.J. and C.G.B.), but I would like to thank them, not only for myself, but for countless old Guy's men and women and many others, including his patients, for writing such delightful, appropriate tributes to the Grand Old Man. May he Rest in Peace.

Yours, etc.,

PAT O'MEARA.

Highbury Cottage,
40, College Street,
Bury St. Edmunds.

High Fees—Low Fees

SIR,—I was interested to read your editorial remarks regarding the recent Government decision to increase the University fees of overseas students.

I hope that all your facts are correct. I doubt whether overseas students do, in fact, pay higher fees than our own, and it is obvious that their Governments have been paying low fees for quite a time. Whatever may be the "pros and cons" of the situation—as it seems that most students, perhaps including yourself, have been rather too quick to see the "cons"—the fact remains that the matter is of more concern to the taxpayer than the student. It was a matter of regret to me to see how prejudiced were those students agitating in this matter, as the more vociferous of the student community usually are. However, one can scarcely blame them, when the public press and the B.B.C. report matters of this kind in a partial manner. I hope that you will ascertain that your factual remarks are correct, and will correct them if necessary.

I do not believe many students at Guy's were involved in these agitations, and that is well, because the record of this medical centre in regard to overseas students, whether undergraduate or postgraduate, is an excellent one. I believe there is no other British Medical School which takes such a high proportion of overseas students. One of the most regrettable aspects of the agitation which has gone on in the Press and amongst students, aided and abetted with gusto by some of their overseas fellows, is that the latter are likely to be improperly prejudiced against this country, which has done far more for the countries of the Commonwealth than she ever receives in return.

Yours, etc.,

ROGER WARWICK.

Anatomy Department,
Guy's Hospital, London, S.E.1.

[ED.—*All overseas students presently enrolled will pay an additional* £50 *per year and all new students beginning a course are to pay* £210 *per year.* cf. Hansard. Vol. 738, No. 708, 16th—21st December. Pages 376—378. Mr. Crosland in the House of Commons.]

Home Guard

SIR,—Passims, March 4th, cannot be allowed to write such inane thoughts under the title "False Economy" without reply.

It is my experience from talks with patients that that poor, voiceless animal known as the taxpayer feels the exact opposite to Passim. As a student with a very modest state grant, I felt we were sent to University to study, but it seems that this view is definitely not "mod".

Strikes, delegates devouring a thousand miles and more a month in their frantic efforts to exhort fellow students to rebel against authority is the pattern of college life in 1967 . . . or is it?

Isn't it criminal that thousands of young British people are being denied a University place to make room for the overseas students? No doubt I will be accused of insularism, but when I see how these so-called new emergent nations behave I must admit to slight misgivings at being asked to pay more towards their education. Of course, there is a way round the impasse—for I am sure the taxpayer will rebel against a move to increase his taxes to avoid higher fees for overseas students.

To quote the last sentence of Passim. "The price of learning should be the same for everyone, no matter where they come from."

Let us keep overseas fees as they are and make these militant neo-communist British students pay a like sum per annum. It could be in the form of an interest free grant during studentship, repayable after graduating on easy terms. This would solve all the problems of the cost of educating foreign students, and MIGHT make our students realise how damned lucky they are.

I expect howls of protest to echo this suggestion; but it won't be from the taxpayer who foots the bill.

Conservative I may be, but I back Crosland in his action on this issue.

Yours, etc.,

L. B. Lux

Strathyre,
Warwick Road,
Hale, Cheshire.

A Legend of Woe

SIR,—I was very interested in Mr. Thomas M. Buchanan's article comparing English and American teaching hospitals. I took to heart his chiding of our students for accepting opinions and not asking for references. He must therefor forgive me if I question the authority for his statement "The financial hardships in British medicine increased since the beginnings of the National Health Service are reflected at Guy's".

Before the last war hospital services were far cheaper to provide than today because there was so much less to offer. Blood-banks, antibiotics, steroids, hormones, heart-lung machines, kidney machines did not exist. Cranial surgery, heart surgery and lung surgery were virtually absent. This was reflected in a much lower staffing ratio. Residents were paid nothing in cash for their services while assistant house surgeons had to pay for their food as well as do without money. Many ward sisters lived on their wards and worked very long hours at exacting duties for a mere pittance. The hospital was always hard up and the *Daily Telegraph* announced our overdraft (was it £400,000) every day. As students, we occasionally collected money in buckets from people arriving at London Bridge Station from 6 a.m. onwards.

No doubt we should have been forming a league of angry young doctors but we were mostly very happy and considered ourselves very lucky to be allowed to do our house jobs unpaid.

It is not my purpose in this letter to advocate any particular method of financing hospital services. I am still a hospital doctor and know all the frustrations and shortages. My only object in writing to you is to assure your younger readers that financial hardships at Guy's did not begin with the National Health Service.

Yours, etc.,

David A. Davies

50, Acacia Road,
Hampton, Middlesex.

What's in a Date?

SIR,—I would like to correct, if I may, an error in the report on the Guy's Boxing Club, printed in the 4th March edition of the *Gazette*.

There is an account, in the *Gazette* dated 8th February, 1873, of a General Meeting of the Fencing and Boxing Clubs in which the new rules were approved. The subscription was increased from 2/6 to 5/- because of "wear and tear" on equipment. This, in itself, presupposes that the club was in existence for at least one year.

As there appears to be no earlier record, one presumes that the Boxing Club was founded in 1872 and not 1877 as stated in your last issue.

Plans are being made for the celebration of the Centenary in 1972, and I would appreciate interesting information or stories regarding the club and its membership.

Yours, etc.,

W. M. SHEERAN.

262, Portland Road,
London, S.E.25.

[SPORTS ED.—*Correct, Sir. However, the earliest official recording in the Boxing Club Minutes was in* 1878.]

NOTICES

Concert in Southwark Cathedral

Guy's Hospital Music Club presents a Concert on Friday, 17th March, at 8 p.m. in Southwark Cathedral.

Programme:—

Gloria in D major—Vivaldi.
Cantata, "Aperite mihi portas institiae"—Buxtehude.
Three arias from "Geistliche Lieder"—Bach.
Hymn to God the Father—Humfrey.
Trio Sonata in C minor—Loullet.

Thirty Club

The Annual Dinner of the Thirty Club will be held on Friday, 19th May, 1967, at The Royal Air Force Club. Dr. H. M. Brown in the chair. Detailed notices have been sent to all members. Will those members who have not yet replied please do so as soon as possible?

E. J. CRISP.
D. J. P. O'MEARA.

Guy's Hospital Dental School

Commencing on Wednesday, 26th April, 1967, a course in Conservative Dentistry, primarily for F.D.S. candidates, will be held at Guy's Hospital Dental School. The Course will consist of six sessions, from 6.00 p.m. to 8.00 p.m. on 26th and 28th April and 3rd, 5th, 10th and 12th May, 1967. Fee: £10 10s. 0d. Further particulars and forms of application, which should be returned as soon as possible, and not later than 4th April, 1967, may be obtained from the Dean, Guy's Hospital Dental School, London Bridge, S.E.1.

Pulse

Got an idea—write it down.
Want it read—publish: but where?
In Pulse—why not?

NURSING SECTION

Drugs

A conference was convened at the Hospital Centre on February 28th between Doctors, Pharmacists and Nurses to discuss the problems of prescription, compounding and administration of drugs. The conference was held under the Chairmanship of Professor A. Wilson—Professor of Pharmacology at Liverpool University.

Drug administration both outside and within Hospitals has, in the past, been under constant review, but not as a National problem. Now, however, most hospitals have begun to institute great changes in their methods of prescription and administration. Previously mistakes were made due to insufficient information about the drugs, inaccuracy in administration times and methods, and illegibility in handwriting.

A number of hospitals have tightened up on their systems, but when a doctor moves to another hospital he may well find the method of writing up drugs totally different to that to which he has been accustomed.

If standardised prescription sheets were used throughout Britain's hospitals then prescription and recording times could be contained on one sheet with clearly defined headings. This would cut down further the present minimal risk in errors of administration for which the nurses are responsible, and errors of prescription which are the doctors responsibility.

Standards in terminology used for drug times would be of great assistance. Use of both Latin and English terms tends to lead to confusion. Each hospital knows what is meant by its own terminology but a standardised method of indicating drug administration times would assist those who of necessity must move from hospital to hospital.

Pharmacists on the whole seem to be more removed from the wards than is advisable and there is often a lack of communication and understanding between the Pharmacy and the Wards. Wards experience difficulty in getting drugs compounded or replenished at the times needed, and the Pharmacy experiences more than great difficulty in recruitment of trained staff.

Drugs hoarded in the ward cupboards by the nurses is a common occurence which must surely increase drug expense. As drug bills constitute a major portion of hospital expenditure, then if hoarding for the unexpected sudden demand were controlled by inspection of the cupboards at periodic intervals by the Pharmacists, there would be a great deal less waste.

Uniformity and standardisation of the colour and shape of their products by the Drug Houses would assist in identification of drugs. Many patients are admitted to hospital with pills which cannot be readily identified and, in some cases, failure to continue administration could be dangerous.

The proposed entry of Britain into the Common Market has necessitated change to the Metric System of weights and measures. Difficulty is experienced however, with the number of foreign drugs now available on the British market and the work involved in calculating the equivalent dose is necessarily time consuming.

Many other problems are apparent on reflection, but from these few comments it is obvious that the amount of work being put in on the standardisation of prescription and recording methods by British hospitals must go on, and until a fool-proof system has been evolved then errors in chemotherapy will occur.

STAFF CHANGES AND APPOINTMENTS

APPOINTMENTS

S/N S. Clay, S.R.N. (Guy's 1962-1966), to Martha Ward.
S/N G. Harris, S.R.N. (United Manchester Hospital), to Radiotherapy Department.
S/N A. C. Petly, S.R.N. (Guy's 1960-1964), to Nuffield B Floor.

DEPARTURES

S/N J. M. Caswell, from the School of Nursing.
S/N L. Kirby, from Esther Ward.
S/N J. Marigold, from York Clinic.
S/N J. Pilkington, from Nuffield House.

SPORT

SOCCER

United Hospital League Champions—will they complete the double? A hackneyed expression but a position of glamour and adoration for footballers. Guy's, having reached the final of United Hospitals' Cup, will have met The London at Cobham on Wednesday, 15th March. The London have beaten U.C.H., St. Bart's and Westminster in previous rounds, while Guy's had a bye in the first round and then beat Charing Cross and St. Thomas' in the subsequent rounds.

Again, United Hospitals should be going on tour at Easter—to Berlin. Guy's are fortunate in having two representatives. Last year they went to Belgium, the party staying in Ostend, and playing one match in Bruges (winning 7—0) and one match in Ghent (1—1). It is hoped that this year's tour will be as successful.

RUGBY

Having endured an unenterprising game between Mary's and The London in the United Hospitals' Cup Final, a game that lacked even the elementary qualities of attractive Rugby (although the Press stated that it was a shade better than the first Final last year between Guy's and St. Thomas'), we were presented in the replay with another uninspiring performance. With the wind and rain, spectators expected very little, and yet neither side could truly adapt their style of play to the conditions. It was with relief that Copeland scored a try for St. Mary's and thus won the competition. A sad reflection that St. Mary's were unable to reproduce the fine performance they exhibited against Guy's in the second round.

When Nuneaton visited H.O.P. we were brutily reminded of the necessity of the penalty-goal. Although Nuneaton are notorious for "hard" play, they displayed deliberate fouling in open field with the result that a Nuneaton player had his name taken—a rare occasion in Rugby Union. The score of 12—0 was the result of three penalties and a drop goal (all by Elliott).

With talk of "tries only" games—a system already present in Welsh Youth R.F.U. and to be adopted by Floodlit Rugby Alliance of Wales—Lord Wakefield's "differential penalties" scheme gathers immediate support.

The remainder of the season has a very colourful programme—Gloucester; Cambridge City for Easter Saturday, and a guest side from St. Andrew's University will play the 1st XV on Wednesday, 22nd March. It is hoped that an evening hop will provide adequate entertainment for our visitors. All are welcome.

The week after Easter sees Thorburn and Ross in France with the British University side, and John Price cruising on the Norfolk Broads.

Re-united, the Club will then go on tour to Lancashire.

Thursday, 23rd March, Guy's "A" XV will play The London in the Junior Hospital Cup. A long period between the Semi-final and the Final has served as a recuperation period following the endless battle with St. Thomas' in the Semi-final. Incidentally, the 2nd M.B. Examination will then have been completed.

HOCKEY

Rain has recently curtailed the Hockey Club. Yet the Folkestone International Hockey Festival and the Paignton Festival for the 1st and 2nd XI respectively are a handsome prospect for Easter.

SWIMMING

Rod Jones, a Guy's Dental Student, has longtime been Captain of both the Welsh and Great Britain Amateur Swimming Teams. He has been further honoured with a place in the London University Team to participate in the British Universities' Swimming Championship next week.

DIARY

RUGBY

Mar. 18.—Gloucester. Away.
,, 22.—St. Andrew's University. Home.
,, 25.—Cambridge City. Home.
Apr. 1.—O. Whitgiftians. Away.

HOCKEY

Apr. 1.—Bromley II (10.45). Home.

BOAT CLUB

Mar. 18.—1st and 2nd VIII. Reading Head of River.
,, 25.—1st and 2nd and Gentleman's VIII. Metropolitan Head of River.

RUGBY

GUY'S v. OLD ALLEYNIANS

At H.O.P. Saturday 4th March, 1967

One could naturally expect the attitude Guy's developed during this game. Meeting Old Alleynians for the second time in three weeks (heavily defeating them 43—10 on the first occasion), they lacked enthusiasm beyond the goal of a "comfortable" win—even this they managed to make rather heavy weather of.

Alleynians, for the first 15 minutes, determined not to be white-washed, seemed spirited until Guy's scored through Thorburn, supporting a threequarter move and side-stepping his way in under the posts. Elliott converted.

Soon afterwards Elliott, providing an overlap, scored the second try, which he subsequently failed to convert.

Two further penalties by Elliott brought the half-time score to 14—0.

Even the much starved Ross was given his meagre ration and scored two tries; first in the corner and a second running in under the posts (both being converted by Elliott).

Finally Rowlands scored, ignoring the two-man overlap outside him. Elliott badly sliced his conversion.

The game was concluded.

We were then pleasantly able to congratulate the Old Alleynians captain (and ex-Guy's player) Dick Stevens and his wife upon the birth of their daughter just before the match.

Guy's: D. Elliott; R. Beacham, J. Price, B. Rowlands, J. Ross; A. Scourfield, P. Swift; E. Neville, G. Hey, J. Davies, C. Neville, M. Cockburn, D. Curson, H. Sharp, C. Thorburn (Capt).

J.G.P.

GUY'S v. NUNEATON

Saturday, 11th March, 1967
Result: won 12—0

Recent fixtures against Nuneaton have not produced exciting rugby, and this match was no exception. A strong wind blew downfield for the whole match but neither side took complete advantage of the conditions.

Facing the wind in the first half, the Guy's pack played a tight, sensible game along the touchline with low raking kicks or well controlled foot rushes. Long, high kicks from the opposition gave Nuneaton territorial advantage but they were too sterotyped in their attacks and too unsure in their handling to cross the Guy's line. Their best opportunity came following a misunderstanding between Price and Elliott, but Curson, in grand foraging form, nipped back to touch down "in goal". Elliott was wide with two difficult penalties into the wind, and Nuneaton similarly sliced a straight 35 yard opportunity. In the forwards, a battle royal was developing between the front rows, and Davies, Hey and E. Neville appeared inspired by the attempted intimidation to produce a fine positive contribution in both tight and loose play. Jumping at No. 3, C. Neville monopolised the front of the lineouts.

In the second half, Guy's did not take full advantage of the wind to set up compromising attacking positions and lacked sufficient zip and application to carry out pre-planned moves. A slow heel, untidy ball and cold hands may have been contributory factors, but Ross—Guy's most potent winger for many years—was left waiting in vain for a pass throughout the afternoon; both he and Price, of the back line, were far superior to their opposite numbers in weight, skill and speed.

Midway through the second half, Guy's opened the scoring with a well-taken drop goal by Elliott from 25 yards out in front of the posts, and a few minutes later kicked a penalty goal when Ross, having gathered a kick, was blatantly tripped by a decerebrate Nuneaton prop who, in addition to having his name taken, supplied Guy's with a string of penalties for consistent use of clenched fists and flailing boots and might justifiably have been ordered to take an early shower! Finally two 35 yard penalties from Elliott completed the scoring.

In summary, this was a dull forward struggle in unfavourable conditions, although the issue was never seriously in doubt. Nuneaton confined themselves to negative, harrying, crude rugby, and it was left to Elliott—an immaculate full-back, whose recognition is long overdue—to supply the winning margin. With a little more speed and decision, the back line could have given both Ross and Price the chance to utilise their ability and thereby give a more genuine impression of the difference between the two sides.

Guy's: Elliott; Price, Beacham, Rowlands, Ross; Scourfield, Swift; Davies, Hey, E. Neville, Cockburn, Hughes, Curson, C. Neville, Thorburn (Capt.).

H. SHARPE

LADIES' SQUASH CLUB

The Ladies' Squash team has had a more successful season than was anticipated as it lost five of its members of last season. In the matches played for the newly-formed University of London League, we have won against Birbeck, Royal Holloway and St. Thomas's, had a walk-over from the Royal Free, and lost to St. Mary's. Despite many cancellations we have played matches against Bedford, Ibis Squash Club, the Middlesex, Bart's, and King's College Hospital, with one drawn, one lost, but winning the rest.

Our thanks go to the physiotherapists and friends whose valuable support we need to make up the team.

A. FALCONER

WATER POLO

U.L.U.
GUY'S v. IMPERIAL COLLEGE II
February 16th, 1967
Result: won 6—1

Guy's produced some of their best water polo of the year in beating a strong and efficient I.C. side. Particularly notable was the accurate mid-field passing between Northcott, Froom and Challacombe which, combined with fast breaking, produced some worthy goals. Thus, by the end of the second quarter, Guy's were leading comfortably 3—0. In the next quarter Guy's had the dual advantage of attacking the deep-end, and one of the I.C. players out of the water for an infringement. However, Guy's were unable to score, as the remaining I.C. players committed themselves entirely to defence. This was soon rectified in the final quarter when Guy's overran the tiring I.C. defenders to produce three goals. Our defence was again efficient with some strong, if not robust, work, by Foulds and Forbes, letting through only one disputable goal at close of play.

Goals: S. Challacombe, 4; P. Ashford, 1; A. Froom, 1.

Guy's: D. Foulds, A. Froom, S. Challacombe, P. Ashford, M. Adkins, A. Forbes, G. Northcott, J. Wood, B. Wright.

P. D. ASHFORD

GUY'S v. GOLDSMITHS
February 23rd, 1967
Result: won 7—4

The most accurate description of this match is shoddy! No real excuse can be made except perhaps the absence of three regular 1st team players, including the captain.

The first quarter saw Guy's defending the deep end. Attacking quickly, a goal was scored in the second minute. This seemed to auger well for Guy's chances in the ensuing minutes. This, however, was not to be. Guy's did most of the attacking but it was a story of poor passes by the forwards with very loose marking and backing-up by the defence.

The change of ends saw the score 2—1 in Guy's favour. The defensive errors increased in the second quarter and Guy's were very lucky to be still in the lead at half-time—3—1. Froom returned after Guy's fourth goal by Challacombe in the third quarter. Three very bad defensive errors in the third quarter made the scores level at 4—4. At this point, in almost sheer desperation, Guy's struggled to lift themselves from the general quagmire of frayed tempers and poor polo playing. This they did —just, and with three quarters gone Guy's were leading 5—4.

The fourth quarter had some panic defence work, and two good shots, one by Froom and one by Northcott, to clinch the match in Guy's favour. Scorers were Froom, 4; Challacombe, 1; Northcott, 1; Ashford, 1.

Guy's were very lucky to win this match, but they must practise general teamwork and passing if they are to survive as a polo team to be reckoned with.

Guy's: Ashford, Challacombe, Evans, Froom (Capt.), Northcott, Taylor, Wood, Wright.

BOAT CLUB

Spring Rowing, 1967

The standard of this term's 1st VIII is well above that of any Guy's VIII in recent years. It was formed partly from last term's successful Junior crew. To obtain the very best performance the crew has had a very full training programme—rowing on Wednesdays, Saturdays and Sundays, and gym training twice weekly. This has meant considerable dedication on the part of the crew and regular coach Mike Preece.

The second VIII have also maintained a high standard in their class, although most members show a certain unwillingness in their training. Their regular coach, Peter Burton, has done much for this crew, often under unsatisfactory conditions. A keen third VIII has also been rowing regularly, and this consists almost exclusively of oarsmen who took up rowing only last term.

Our new motor launch has proved to be a very worthwhile investment and has made coaching far more effective. Our thanks go to the regular coaches and also to Vice-Presidents Dr. H. Freeman, Mr. D. Gurney and Dr. D. Cooper who have all been good enough to give time to coaching.

University of London Head of the River

This is the first of the "Heads" and starts the Competitive Season of the year. Most London Colleges enter their crews, which numbered twenty-seven this year. In a "head", crews set off in a procession and race against the clock. The results are based on the time taken and not on the order of finishing. The course is that of the Boat Race (Putney to Mortlake), which is 4¼ miles, although times cannot be compared owing to changing conditions.

1st VIII

Starting 11th, a confident 1st VIII was eager to show its capabilities. After a good start in rough water, the crew soon settled down for this long row in a comfortable rhythm, and after 15 minutes had overtaken four of the crews which started before them, and were catching up with some more at the finish. After this creditable performance the crew deserved their fourth place in the overall result, being the fastest hospital crew in the race. Their time was beaten only by Tynian (the U.L. 2nd VIII), Imperial College, and University College (a crew containing many U.L. 1st VIII oarsmen)

Crew:

Bow A. Batch
2 P. Moulder
3 G. Stygall
4 N. Bax
5 A. Hodgkisson
6 J. Miller
7 P. Gooder
Stroke I. Grimble
Cox T. Kirk

2nd VIII

Starting 15th, they had a very good row, overtaking two crews and catching up several others. They finished seventh in the overall result, being only four seconds behind Bart's, who treat rowing as a major sport. This performance is unparalleled in second eight history.

Crew:

Bow P. Robinson
2 R. Knowles
3 J. Osborne
4 R. Tudor-Williams
5 I. Wilkinson
6 A. Fenn
7 M. Fortune
Stroke P. Hunt
Cox R. Stanley

3rd VIII

Started 22nd and overtook one crew, and finished 22nd in the overall result, being faster than some College's 2nd eights.

Crew:

Bow C. Wilde
2 T. Haywood
3 P. Wright
4 B. Parker
5 P. Sharples
6 T. Gould
7 J. Klossok
Stroke M. Nockles
Cox J. K. Skuse

Summary of Results of fastest eight crews

Position	Crew	Time
1	Tyrian	22.49
2	Imperial Coll. I ..	23.17
3	University Coll. I ..	23.35
4	Guy's Hospital I ..	23.43
5	Imperial Coll. II ..	23.49
6	Bart's Hospital I ..	23.58
7	Guy's Hospital II ..	24.02
8	Queen Mary's Coll. I ..	24.39

GEOFFREY STYGALL (Sec.)
MARTIN MACE (Capt.)

HOSPITAL INFORMATION

PRIZES

Sands Cox Scholarship in Physiology
P. J. Steer—Scholarship

Gowland Hopkins Prize in Biochemistry
D. E. Ward—Prize
J. L. Bates—Certificate

Michael Harris Prize in Anatomy
H. J. H. Williams—Prize
R. J. Wainwright—Certificate

Charles Forster Prize in Cardiology
March, 1967
The following awards have been made:—
D. E. P. Shapland — Prize
R. A. C. Hughes, G. D. Schott } Certificates

PERSONAL

DENTAL ASSISTANT with view to partnership required in conservative three-man practice in Eastbourne. Tel. Eastbourne 30406.

FOR SALE—two bedroomed Wates-built Maisonette, Sydenham. Within easy reach of London Bridge. £5,500. Tel. Syd 8044 any time.

TWO GUY'S DOCTORS find General Practice interesting. Duty rota. Appointment system. Ancillary help. Third Partner required to share their interest. Details from Drs. Bush and Muir, Hayesbank, Canterbury Road, Ashford, Kent. Telephone Ashford 1675.

CHANGE OF ADDRESS

Dr. M. H. de Groot, 101, Carrington Road, Point Chevalier, Auckland, S.W.2, New Zealand.

BIRTHS

BEDELL—To John and Elsa Bedell, a son, Rodney John, on 4th February, 1967, at Shell Hospital, Point Fortin, Trinidad. A brother for Katherine Anne and Donna Elizabeth.

LEWIS—On 20th December, 1966, to Patricia (née Marsh) and Dr. Joseph Lewis, a daughter, Jane Victoria, a sister for Jeremy and Sarah.

PENNY—On 4th March, 1967, to Gillian (née Needle) and Dr. Richard Penny, a daughter, Amanda Sally, sister for Susan and James.

WILLEMS—To Anthony and Annette (née Rake) on February 26th 1967, at Churchill Hospital, Oxford, a son, Paul Anthony, a brother for Caroline, Zazie and Juliette.

ADOPTION

LEWIS—By Patricia (née Marsh) and Dr. Joseph Lewis, a daughter, Sarah Anne, born 2nd April, 1966. A sister for Jeremy and Jane.

ENGAGEMENT

HENDRICK—FALCONER—The engagement is announced between Dr. David John Hendrick and Miss Alex Margaret Falconer.

MARRIAGE

KELLY—HARRIS—On October 15th, 1966, at All Saints' Church, Maidstone, Kenneth Kelly, N.D.D., to Kathleen M. Harris, S.R.N., S.C.M., O.N.D.

We would like to remind our readers that all copy for inclusion in the Gazette must be received eight days before the publication date.

Personal notices one shilling per word (Minimum £1. 1s. 0d.)
Birth, Marriage, Death and Change of Address notices are without charge to subscribers.
Non-subscribers will pay £1. 1s. 0d. for all notices other than Personal.

GUY'S HOSPITAL GAZETTE

EDITORS D. S. ROBINS and C. B. BROWN
SPORTS CORRESPONDENT J. G. PAYNE
NURSING CORRESPONDENT E. A. MALPAS

FORTNIGHTLY TWO SHILLINGS VOLUME 81 NUMBER 2053

The opinions expressed in these columns are solely those of their authors and are not to be taken as the views of the Hospital as a whole.

PASSIM

Its all in a Name

Among the many intangible ingredients that go towards creating that equally intangible quality "character" the use of eponyms must appear high on the list. The degree to which this quality is recognized in Guy's is perhaps a measure of a long history which dates from the very founding of the Hosptal. It is the only London teaching hospital to be named after its founder, although one must be grateful for the subsequent dropping of the second half of the original title, i.e. "for Incurables". Be they buildings or wards, it is by the names of people that they are known. The tradition continues: following the removal of the letters A, B, C, D from the floors of the York Clinic a short while back and their substitution by names of previous eminences amongst Guy's psychiatrists, the adult psychiatric clinic in Snowsfields, after a period of name-borrowing from the street of its entrance, is now to be called "The Munro Clinic" in commemoration of the late Dr. T. A. Munro who, in the recent past, directed the York Clinic. Equally satisfying, though perhaps a little less appropriately, the residential section of Matron's House has been renamed "Conybeare House". The nameplate looks out onto St. Thomas's Street close by the main entrance to the hospital—a position which ensures a constant reminder of the name of one who was so much a part of the hospital and street.

Critics might ponder on the suitability of Keats' name being appended to the private consulting rooms of the hospital, but whatever their comments may be, these names are infinitely more interesting than the uninspiring, almost sinister modern hieroglyphics such as J17 that are so much a feature of other places.

We would be grateful if any reader who has a spare copy of the following issues of the *Gazette* would let us have it, or them, as we are short of these for our records : March 21st, 1964; October 7th, 1964; December 11th, 1965.

Study of Man

The five-year International Biological Programme begins on July 1st and is the biological successor to the International Geophysical Year. The aims of this extensive investigation is bifold—to further ecological understanding of the earth's biosphere, and to apply this knowledge to improving biological productivity and human welfare.

Forty countries will be participating in the comparative study of living comunities on land, in the sea and fresh water, under a whole range of contrasting environments both natural and artificial. For example, in the Human Adapability Section such comparative studies will elucidate the ways in which the stresses of different environments—desert, tropical, arctic, mountain and industrial—can be met.

During the past two years a number of preliminary investigations have been carried out. Some of the most interesting findings have come from those on populations indigenous to high altitude; those living at 11,000 feet and over. The I.B.P.s' programme involves combined genetic, demographic, nutritional, and physiological investigations of communities in nearly all the mountain areas of the world—in the Andes, Himalayas and in Ethiopia. In Ethiopia an expedition supported by the Royal Society made comparative studies on three neighbouring populations living at 5,000 feet, 10,000 feet and 12,000 feet respectively. The blood group and demographic data suggest that the populations are probably genetically very similar, so that differences between them have been acquired physiologically or during development. The highlanders were heavier and their chest dimensions definitely larger in both males and females, as to be expected as a result of the great increase in respiratory activity and capacity. This is a feature of high-altitude acclimatization found also amongst Himalayans and Andeans. However, it was surprising to find that the increase in red cells and haemoglobin appeared to be by no means so marked amongst the African highland populations. Whether this is a result of some dietary deficiency or whether it points to a particular local adaptation involving perhaps improved tissue utilization of oxygen, remains for future investigation.

Similar studies are planned for investigating the ecology of circumpolar peoples and those living in hot climes both desert and jungle—for example, in New Guieas, Central Africa, the Kalahari, Sahara, and South America.

Another world survey is concerned with the assessment of growth and development of children in a variety of climatic, nutritional and economic conditions, using standardized methods of measurement. This work will be co-ordinated by Professor Tanner and his department at the Institute of Child Health.

One hopes that through this programme more interest will be devoted to the at present overwhelming problem of adapting society's wants to its needs!

A Whisper

While the Press has been clamouring on about the difficulties between hospital junior staff and their administrators, those involved at Guy's have quietly gone about their business in such a way that in the future there are to be regular monthly meetings between the Superintendent and representatives of junior and middle grades of staff to discuss problems and propositions of concern to either or both. Jericho's walls needed only seven inspired trumpets.

Residents' Play

One of the striking features of a strong institution is its ability to laugh at itself. The exercise, when in the nature of the Residents' Play, may rarely change something through its satirical quality but in its entirely parochial form of entertainment brings even greater strength to the object of its attack. For many years now this annual event has played to packed audiences, provided many with enjoyment, a few with annoyance, but effecting little but good to the hospital community. Such a saga must, of course, have its historians, and Dr. T. H. Hills, who was responsible for the Play's revival after the last war and who has maintained a close contact with its subsequent course, is now in the process of writing this history in the form of a small book. He would be particularly grateful to anyone who can furnish him with any form of Playana, be they programmes, information of previous participants, anecdotes or anything even remotely connected with the Play.

We offer our congratulations to Dr. D. G. A. Westbury on his appointment as Consultant Forensic Psychiatrist to the Home Office and Newcastle Regional Hospital Board. This appointment is the first of its kind in England and Wales and begins 1st April, 1967.

We offer our congratulations to Dr. Andrew Fairley, who has been appointed Consultant Physician, Geriatric Service, in the Mansfield area.

We congratulate Dr. Harry Keen on his appointment as Reader in Medicine in respect of his post in the Department of Medicine.

GUY'S DIARY

APRIL			
3rd	M.	1.00	Clinical Lecture. Profesor KNOX.
6th	Th.	1.00	Clinical Lecture. Dr. Dorothy F. EGAN. Principal Medical Officer of the Greater London Council. "Play in relation to the development of the young child".
7th	F.	1.00	Clinical Lecture. Dr. MACLEAN. "Cerebro-Vascular Acidents".
10th	M.	1.00	Clinical Lecture. Mr. ROSS. "The Heart as a Musical Box".
11th	Tu.	1.00	Clinical Lecture. Mr. LEWIS.
		8.00	Music Circle. Mr. H. BERRY. East Wing. "Topical Trends in Classical Music".
14th	F.	1.00	Clinical Lecture. Professor BUTTERFIELD.

Errata: Mr. Robert Hunt qualified L.D.S., R.C.S.(Eng.) in 1935 and not in 1925 as printed in our last issue.

THE MEDICAL IMPORTANCE OF FLUORINE*

By R. H. Savage

Introduction.

Fluorine is found in small quantities in most body tissues, but is especially abundant in bones and teeth. It is a trace element in our normal diet, but experiments have failed to show that it is a nutritional essential for normal health. In fact, the element is so ubiquitous that it would be almost impossible to have a fluorine-free diet. From its initial source in igneous rocks, fluorine occurs in the soil and hence in surface and spring water, vegetation, and fauna. It is also airborne as a result of volcanic eruptions and industrial effluents.

Occurrence of Fluorine.

Fluorine occurs widely and sparingly in rocks, particularly those of volcanic origin, as fluorides and fluorosilicates. It is an extremely active element and for this reason is very rarely found uncombined. The word fluorine is therefore used rather loosely in this paper to apply to some compound of fluorine. Henri Moissan, the French chemist who first isolated the element in 1886, records free fluorine as having been found as an inclusion in crystals of fluorspar from Quincie. It also occurs free as occluded gas in dark violet or nearly black fluorspar which has in part been decomposed by radiation from associated radioactive elements, and this is the case with the "stinking fluorspar" of Wolsendorf in Bavaria. However, fluorine is the most electronegative element known, and apart from these isolated examples never occurs native. Its extreme reactivity is illustrated by the fact that it combines explosively with hydrogen, even in the dark and at $-210°C$. It has a tremendous affinity for hydrogen and decomposes

*This paper was awarded a joint prize by the Guy's Hospital Physiological Society for 1966-67.

water to form hydrogen fluoride, liberating oxygen highly charged with ozone;

$$F_2 + H_2O = 2HF + [O]$$
$$[O] + O_2 = O_3$$

Fluorides are readily formed by the action of hydrofluoric acid on metals and their compounds, and this explains some of the occurences of metallic fluorides in geological formations.

When molten magma, thrust from deep-seated sources within the earth into the overlying sedimentary rocks, begins to cool and crystallise, the least volatile constituents separate out first to produce silicates and fluorosilicates. This separation effectively concentrates the volatile constituents of magma with the result that the residual portions are rich in fluxes, various gases and vapours. The liquid fraction leads to the formation of pegmatitic deposits in which fluorine is commonly fixed, in combination with phosphorus, in the mineral apatite. The gaseous fraction produces pneumatolytic deposits where again we find apatite and fluorides. The final consolidation of magma takes place from the hot, water-rich solutions to form hydrothermal deposits. These hot solutions, when forced into cracks and fissures within sedimentary rocks, cool to form hydrothermal veins of fluorides.

The commonest fluoride is fluorite or fluorspar, calcium fluoride CaF_2, and is very widely distributed. It occurs in hydrothermal veins and replacement deposits. It is found in tin veins of pneumatolytic origin, and as a minor constituent of some granites. It even forms the cementing material of certain sandstones where it has replaced the calcareous cement. "Blue John" is a purple variety of fluorspar found in Derbyshire, where its formation in hydrothermal veins coincided with a leak of oil from the Carboniferous Limestone into which it was intruded. Incidentally, the name fluorite comes from the latin "fluere" meaning to flow, and is derived from the fact that fluorspar has a low melting point, 1360°C., thus being used as a flux in metallurgy. Indeed, petrologists have assigned this role to fluorite in magmas, believing that it is important in promoting fluidity[1]. Another comomnly occuring fluoride is cryolite, a fluoride of aluminium and sodium, $3NaF.AlF_3$, which occurs in pegmatite veins in granite, and is a commercial source of aluminium.

The third important source of fluorine is apatite, rock phosphate or fluorapatite, $3Ca_3(PO_4)_2.CaF_2$, where fluorine constitutes 7% or more of the rock. Apatite occurs as a primary constituent of igneous rocks, but only in small amounts. It is also present in small quantites in most metamorphic rocks, and especially in crystalline limestones. Rock phosphate principally comprises a variety of deposits of organic origin such as phosphatic beds, bone beds, coprolites and guano; coal also contains variable amounts of apatite. Over a hundred years ago, Owen Rees read a paper to the Geological Society, drawing attention to the fact that whereas the fluorine content of recent bones is very small, fossil bones may contain up to 15% of fluoride. Fifty years later, the French physicist and metallurgist, Marie-Adolphe Carnot, showed that fossil bones acquire an increasing content of

fluorine the older they become, until the original hydroxyapatite, which forms 90% or more of bone, is completely converted to fluorapatite. This signified the birth of fluorine dating of fossil bones. Table 1 illustrates the relative fluorine contents of Palaeozoic, Mesozoic and Caenozoic bones, compared with modern bones. [2, 3].

Table 1. To illustrate the relative amounts of fluorine taken up by the hydroxyapatite in bones according to their age. The proportion of fluorine to calcium phosphate in apatite is taken as unity.

Geological era.	Age. oldest date in million years.	Proportion of Florine to Calcium Phosphate.
Modern bones		0.058
Quaternary bones ...	3	0.33
Tertiary bones ...	65	0.62
Mesozoic bones ...	225	0.91
Palaeozoic bones ...	570	0.99

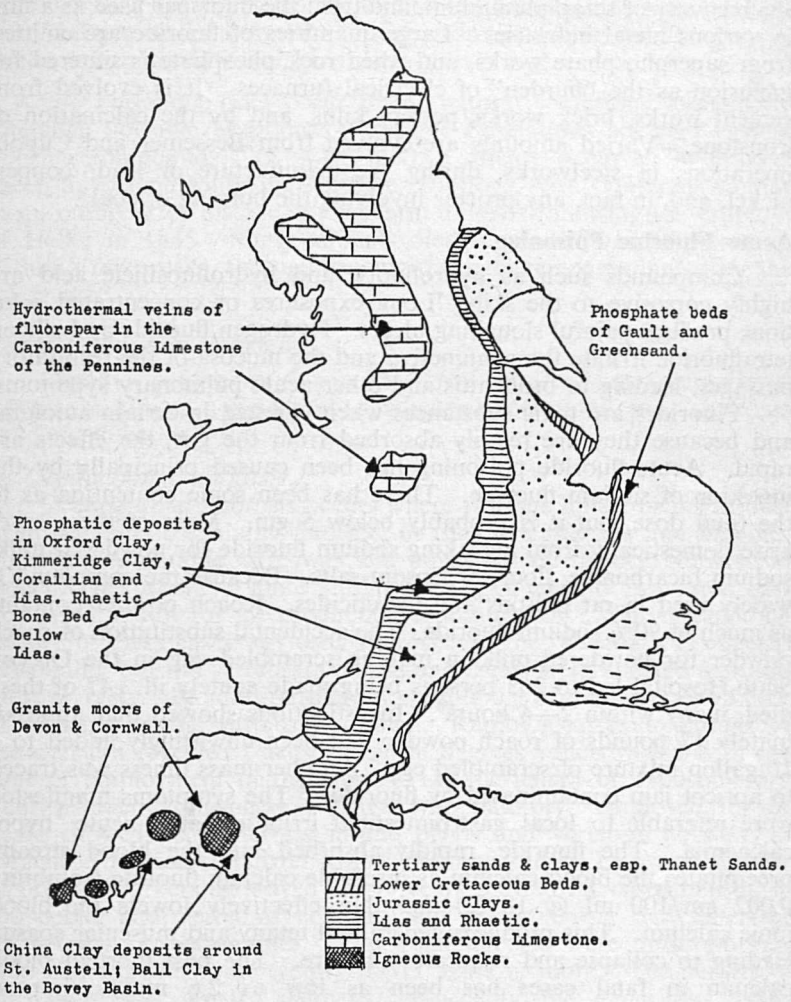
This affinity of the element fluorine for calcium phosphate is reflected in the normal physiology of bones and teeth in vivo. Fluorides are readily absorbed from the intestines and about 75% excreted in the urine. The remainder constantly accumulates in the bones and teeth, converting some of the hydroxyapatite to fluorapatite. This explains the variability of the results of analyses of the fluoride content of bones and teeth, since the amount present will depend on the age of the person and the amount taken in with the diet.

The chemical affinity between calcium phosphate and fluoride in solution is so considerable that solid dicalcium phosphate has been used in filtering devices for the removal of undesirable amounts of fluorine from drinking water.

The rocks of England that are rich in fluoride include the granite masses of the Devonshire and Cornish Moors, where both calcium fluoride and apatite are found. Kaolinisation of granite gives rise to China Clay and Ball Clay found around St. Austell and in the Bovey Basin respectively, both containing large amounts of fluorite and apatite. The Carboniferous Limestone of the North and South Pennines is well intruded by hydrothermal veins of fluorspar. Extensive apatite deposits are found in the Jurassic and Lower Cretaceous clays, rich in reptile remains and phosphatic beds, e.g. Lower Lias, Kimmeridge Clay, Oxford Clay and Gault Clay. The Rhaetic Bone Bed is a consolidated mass of fossil vertebrates. Of the Tertiary sands and clays, the Thanet Sands contain apatite and give rise to waters with a high fluorine content. (See Map 1).

Vast amounts of volatile fluorine compounds are liberated with the exhalations of active volcanoes. A great deal of submarine volcanic activity is going on all the time, and this may possibly be a major source of oceanic fluorine. The fluorine content of sea water of normal salinity is 1.4 p.p.m., the value varying in proportion to salinity. Most fresh water lakes and rivers contain about 1 p.p.m., and this difference in the fluorine content of sea and fresh water is almost certainly the cause of the higher fluorine contents of the bones of marine animals, compared with those of the terrestrial fauna[4]. See Table 2.

SKETCH MAP TO SHOW PRINCIPAL FLUORINE-CONTAINING ROCKS OF ENGLAND


Hydrothermal veins of fluorspar in the Carboniferous Limestone of the Pennines.
Phosphate beds of Gault and Greensand.
Phosphatic deposits in Oxford Clay, Kimmeridge Clay, Corallian and Lias. Rhaetic Bone Bed below Lias.
Granite moors of Devon & Cornwall.
China Clay deposits around St. Austell; Ball Clay in the Bovey Basin.
Tertiary sands & clays, esp. Thanet Sands.
Lower Cretaceous Beds.
Jurassic Clays.
Lias and Rhaetic.
Carboniferous Limestone.
Igneous Rocks.

Note: The areas of chronic endemic fluorosis correspond closely to the areas of fluorine-containing rocks shown above.

Table 2. To compare the fluorine contents (in gms. %) of bones of marine creatures with their terrestrial or freshwater equivalents.

Fauna	Marine	Terrestrial
Mammals	0.66	0.039
Birds	0.33	0.044
Fish	0.28	0.031

A further source of fluorine is industrial contamination. Gaseous and particulate fluorine is emitted from the electrolysis of cryolite during the manufacture of aluminium, from the fluxes used during the recovery of scrap aluminium, and from the fluorspar used as a flux in various metal industries. Large quantities of fluorine are emitted from superphosphate works, and when rock phosphate is sintered for inclusion as the "burden" of electrical furnaces. It is evolved from cement works, brick works, pottery kilns, and by the calcination of ironstone. Varied amounts are evolved from Bessemer and Cupola operations in steelworks, during the manufacture of lead, copper, nickel, and, in fact, any process involving the burning of coal[5].

Acute Fluorine Poisoning.

Compounds such as hydrofluoric and hydrofluosilicic acid are highly corrosive to the skin. Long exposures or concentrated solutions produce painful sloughing ulcers. Hydrogen fluoride and silicon tetrafluoride irritate the conjunctiva and the mucosa of the respiratory passages, leading to bronchitis and other acute pulmonary sypmtoms.

Fluorides are toxic substances when ingested in certain amounts, and because they are readily absorbed from the gut, the effects are rapid. Acute fluoride poisoning has been caused principally by the ingestion of sodium fluoride. There has been some contention as to the fatal dose, but it is probably below 5 gm. Most of these cases arise domestically from mistaking sodium fluoride for powdered milk, sodium bicarbonate, flour, or Epsom salts. Because the compound is widely used in rat poisons and insecticides. Roach powder contains as much of 90% sodium fluoride. The accidental substitution of roach powder for powdered milk in making scrambled egg in the Oregon State Hospital led to 263 persons being made acutely ill. 47 of these died, many within 2—4 hours[6]. Investigations showed that approximately 17 pounds of roach powder had been unwittingly added to a 10 gallon mixture of scrambled egg. Another mass illness was traced to apricot jam contaminated by fluoride[7]. The symptoms manifested were referable to local gastrointestinal irritation and acute hypocalcaemia. The fluoride, rapidly absorbed into the blood stream, precipitates the blood calcium as insoluble calcium fluoride (solubility 0.002 gm/100 ml @ 18°C.) and thus effectively lowers the blood ionic calcium. This produces generalised tetany and muscular spasm, leading to collapse and respiratory failure. The post mortem blood calcium in fatal cases has been as low as 2.6 mg.% (normal 9—11 mg. %). Irritation to the gastrointestinal mucosa produces severe nausea, vomiting and diarrhoea; blood is frequently present in the vomitus and faeces due to gastrointestinal haemorrhages. The post mortems in the Oregon State Hospital poisoning revealed that the mucosa of the stomach, duodenum, and first part of the jejunum was oedematous and hyperaemic, the stomach contents were mucinous, and the colon was empty except for portions of undigested food, indicating the ferocity of the diarrhoea.

In the December of 1930, the Meuse Valley around Liege was shrouded in a particularly heavy fog. During this fog several thousand people suffered acute pulmonary attacks and there were 60 deaths.

The Meuse Valley is a major industrial region of Belgium, and it was thought at the time that the poisoning was due to toxic gases such as the oxides of sulphur exhaled by the factories. However, it is very probable that hydrogen fluoride and silicon tetrafluoride were evolved from the steelworks and metal industries in the district, and condensed in the fog to produce a highly dangerous smog[8].

Acute poisoning does occur under natural conditions, principally following volcanic eruptions. Volcanic exhalations are very rich in fluorine compounds. In A.D. 1100, a disease occurred in grazing sheep in Iceland following volcanic eruptions, with symptoms similar to an outbreak of disease among farm animals following the eruption of Helka in 1845. Many animals died of acute fluorine poisoning within a few weeks, through grazing on herbage contaminated by the fallen ash[9].

Chronic Fluorine Poisoning.

Chronic poisoning occurs in three ways, as an occupational disease, as a disease incidental to industrial operations, and as chronic endemic fluorosis.

(i) *Occupational fluorosis.*

Occupational fluorosis occurs where workers inhale or ingest dust from minerals containing fluoride, or fumes of fluorine and its compounds. A notable case was the poisoning of factory workers in Copenhagen where cryolite shipped from Greenland is broken and powdered, readw for the production of aluminium[10]. The outstanding feature of these cases was osteosclerosis; all the skeleton was affected eventually, but the vertebral column and pelvis were affected first and most severely. In addition there was drooping of the head and a lack of mobility of the vertebral column. Radiological examinations of the skeleton revealed osteosclerosis in degrees which varied with the time of employment of the worker, i.e. the length of exposure to a fluoride-laden atmosphere. Those who had been employed for $2\frac{1}{2}$ years showed osteosclerosis in the pelvis and vertebral column, as evidenced by coarse blurred trabeculae and diffuse increased density of bone. Workers employed for $4\frac{1}{2}$ years showed increased density in the pelvis and vertebral column, and osteosclerosis had extended to the ribs and extremities. The worst affected were those workers who had worked in the factory for 11 years or more. The density of all bones was greatly increased, especially the cancellous bone. Extremities were thickened, and there was considerable calcification of the ligaments of the neck and vertebral column. There was also diffuse pulmonary fibrosis. Altogether, the teeth showed a high incidence of caries and neglect.

(ii) *Associated industrial fluorosis.*

The discharge of fluorine by factories which utilise fluorine-containing minerals has frequently been the source of a number of outbreaks of fluorosis in neighbouring farms, e.g. around superphosphate works in Italy, France, and Germany, and aluminium works in Switzerland, Norway, and Italy. There have been outbreaks

in this country associated with brick works and the calcination of ironstone. In the latter process the raw ironstone is mixed with about 7% of its weight of coal and ignited in the open, fresh layers being added to form a smouldering mound, the complete calcining of which takes several weeks. By this process the weight of ironstone is reduced for transport, and the ore rendered sufficiently porous for direct reduction in blast furnaces. However, during the process smoke drifts onto neighbouring farms, and in 1946 an outbreak of fluorosis was reported in Lincolnshire, associated with one such calcination[11]. Cattle on the nearest farm were stunted and lame, and the owner described some of the earlier cases as having to be destroyed after "crawling on their knees". Mineral analysis showed 1200 p.p.m. fluorine in the ironstone itself and 100—180 p.p.m. in the various coals used. The calcined ore contained only 300 p.p.m., revealing a considerable loss of the original fluorine. The fluorine is believed to come off as gaseous silicon tetrafluoride which, reacting with atmospheric moisture and ammonia from the coal, condenses on the smoke particles as ammonium fluoride and silico-fluoride, and drifts onto the pastures. A straw stack about half a mile away showed 490 p.p.m. fluorine on the outside, wheras the interior contained only 70 p.p.m.

The general picture shown by livestock on contaminated pastures is one of stunted appearance. The animals are generally disposed of because of severe lameness and emaciation, the latter being probably due to the fact that fluorine is an enzyme inhibitor and interferes with certain metabolic pathways. Later stages show enlargement of the bones, especially the jaws, metacarpals and digits. There is frequently gross deformity of the chest due to the spontaneous fracture of several ribs. The development of symptoms is especially rapid in the case of cows in milk, presumably due to their incerased calcium metabolism. However, the milk from affected cows contains only slight increases in the fluorine content. The enamel of the teeth is mottled and the teeth themselves worn right down in many cases.

(iii) *Chronic endemic fluorosis.*

Chronic endemic fluorosis has been shown almost invariably to be associated with drinking water containing a high fluorine content, the water having come from wells or having flowed directly from rock formations rich in fluorine. The most commonly observed symptom is mottled enamel of the second dentition which tends to be rather brittle. In childhood, fluorides affect the function of the ameloblasts during the formation of enamel and the cementing interprismatic substance fails to develop. The enamel prisms are incompletely calcified, and the enamel in places loses its translucency, becomes whitish and has a chalky appearance. There is frequently pitting of the surface and chipping of the brittle enamel. The staining is presumed to be due to a mineral or pigmented substance deposited in the defective enamel. The colour may vary from yellow, through brown to black, and is arranged in irregular patches or transverse bands. In severe cases there is selective abrasion of the teeth.

In parts of the world where endemic fluorosis is severe, there are characteristic bone deformities. Osteophytic formations are produced, calcification of tendons, ligaments and fascia, and almost complete synostosis of various joints, especially of the vertebral column. The density of the bone is increased, the structure is indistinct to X-rays, and fractures are common. Chronic endemic fluorosis occurs in many parts of the world, but notable examples are the Punjab of India, South Africa, and the "darmous" region of North Africa.

A field survey carried out in the Bhatinda region of the Punjab revealed 14 p.p.m. fluorine in the drinking water. 90% of the population had mottled teeth and 46 cases of skeletal fluorosis were examined in detail[12]. Stiffness of the back and legs was a universal complaint, and there was slowness and limitation of movements of various joints, particularly in the spine and hip joint. There was almost complete immobility of the thoracic cage so that respiratory excursions were reduced. Bony exostoses were detected along the palpable borders of long bones or near the olecranon process; these bony nodules varied from the size of a sago grain to that of a walnut. In advanced cases the bones appeared structureless and chalky. Such changes were most pronounced in the spine and particularly in the cervical region. There was irregular new bone formation with considerable osteophytosis and lipping. The interspinous and other spinal ligaments were calcified, and this accounted for the difficulty of entering the subarachnoid space for a lumbar puncture. In the pelvis there was considerable osteosclerosis of the iliac crest and ischial tuberosity, exostoses on the margins of the sacrum, and ossification of the sacropinal and sacrotuberous ligaments. Irregular periosteal bone formation was noticed along the insertion of tendons, ligaments and fascia, and the interosseous membrane in the forearm and legs. The degree of osteosclerosis was related to the water level of fluoride and the duration of intoxication. Osteosclerosis in the spine leads to narrowing of the neural canal and compression of the spinal cord. Thus the fluorosis was associated with neurological complications, notably compression paraplegia. This produces both upper and lower motor neurone lesions so that, according to the location of the osteostenosis, symptoms varied from weakness in some muscles to exaggerated reflexes in others.

Endemic fluorosis occurs in many areas of South Africa, Pretoria being a well-known example. In the Springbok Flats to the north of Pretoria, the rocks belong to the Ecca Beds of the Karroo formation, resting in igneous rocks of the Bushveld Plutonic Complex. The dolerite of the igneous rocks is rich in apatite, and the Ecca sandstones contain detrital apatite, so it is not surprising that water from wells in the district contain about 12 p.p.m. fluorine. A survey carried out at the farm and quarries of Kalkheuvel, some 42 miles north of Pretoria, revealed typical symptoms of endemic fluorosis[13]. The most advanced case showed complete rigidity of the entire spine with total restriction of head movements. The subject was permanently bent double.

"El Darmous" is a term originally applied to a condition affecting the permanent dentition of livestock and human beings in certain parts of Algeria, Morocco, and Tunis, where there are rich apatite deposits. The water which has passed through these beds is charged with fluorine, and dust storms contaminate the herbage and water supply[14]. The fluorosis leads to characteristic changes in bones and teeth, and cases of spontaneous fractures in horses and mules have been reported[15].

Endemic fluorosis does occur in England in what one might describe as the endemic fluorosis belt associated with water supplies coming from the fluoride-rich beds mentioned previously. This belt extends, chiefly in rural areas with their local well-water, from Cornwall, north-eastwards through Somerset, into Oxfordshire, between the Cotswold and Chiltern Hills, on into Northamptonshire, thence northwards to Derbyshire, and up the Pennine Chain. It also includes parts of East Anglia and Essex, a notable locality being Maldon and the surrounding district. The well-water, obtained from the Thanet Sands overlying the chalk, contained 5—6 p.p.m. fluorine. Besides mottling of the teeth, rheumatism and arthritis were prevalent, and there was a high incidence of bone fractures[16]. On giving Maldon water, concentrated ten times, to young rats on a normal diet, there was retardation of growth, characteristic changes in the teeth, bones were brittle and easily fractured, degenerative changes in the alimentary tract, increased water intake and diuresis, and mild nephrosis.

This is one of the few references to the fact that the excretion of fluorine may damage the kidney in cases of chronic fluorosis. A survey on fluorosis in Aden records that, apart from the usual skeletal symptoms, 11 out of 12 patients examined had albuminuria[17]. It would therefore appear that long-term excretion of fluorine through the kidneys causes a general nephrosis, in that the albuminuria indicates glomerular damage, and the diuresis of the rats suggests an impaired ability to concentrate urine. However, it should be emphasised that the nephrosis, when it does occur in cases of chronic fluorosis, is only the result of large amounts of fluorine being excreted over many, many decades. The fact that the blood fluorine of subjects exhibiting fluorosis does not differ signficantly from normal persons, both 2—3 p.p.m., is an indication of the efficiency by which fluorine is removed from the system by excretion in the urine and deposition in bone. Fluorine anaylsis of urine is an index of the fluorine intake, e.g. normal subjects drinking water containing 1 p.p.m. fluorine excrete 0.24—0.84 mg. in 24 hours, whereas persons exposed to much greater amounts of fluorine, e.g. working in an aluminium plant, excreted 5.22--11.65 mg./24 hours[18].

Fluorine and Endemic Goitre.

Endemic or simple goitre occurs in many parts of the world where there is a deficiency of iodine in the diet. When there is a diminished iodine uptake by the thyroid gland, the level of thyroid hormones produced is reduced, and this stimulates the pituitary to release more thyroid stimulating hormone, to which the thyroid

responds by enlarging. In this way it increases its capacity for accumulating iodine and thus manufactures more thyroid hormone. However, in some parts of the world there is no marked deficiency of iodine in the water supply, but simple goitre is still present, and this is due to the presence in the diet of substances known as goitrogens which inhibit the normal metabolism of the thyroid. Experimental goitre has been produced in dogs and rats by including sodium fluoride in the diet[19]. Rats, hens, and dogs developed goitre when given fluorine-containing water from goitrous districts[20]. It has been shown that fluorine does accumulate in the thyroid gland, and in some way reduces the synthesis of thyroxine. For this reason fluorides have been used successfully in the treatment of thyrotoxicosis.

It is therefore not surprising to find that in many parts of the world endemic fluorosis and endemic goitre are associated. Cretinism was frequently found in the high fluoride areas of the Punjab[21]; dogs, goats, and human beings all had goitre. In England, the decrease of endemic goitre in the last fifty years, as well as the decrease in endemic fluorosis, can be attributed to the improvement of village water supplies and the closure of wells. However, there was a belt of endemic goitre in England, coincident with the zone of endemic fluorosis, and including such well-known examples as "Derbyshire Neck". In coastal margins of Essex, although there is a high degree of dental fluorosis, there is no goitre, as opposed to inland regions. This may be explained by the high fish diet affording a high intake of iodine in the coastal villages, which in some way outweighs the goitrogenic capacity of the fluorine, and adequate amounts of thyroxine are produced.

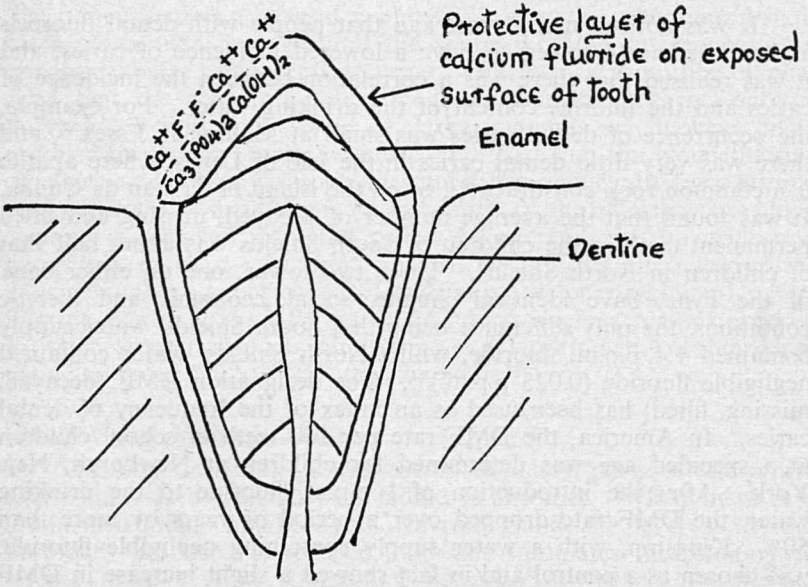
Fluoride and Dental Caries.

It was noticed many years ago that people with dental fluorosis and mottled teeth semed to have a lowered incidence of caries, and it was realised that there was a correlation between the incidence of caries and the fluorine content of the drinking water. For example, the occurrence of dental caries was small at Maldon in Essex[22], and there was very little dental caries in the Isle of Lewis, where apatite is a common rock constituent[23], or on the island of Tristan da Cunha. It was found that the average number of decayed, missing and filled permanent teeth in the children of South Shields was about half that of children in North Shields. These two towns, one on either bank of the Tyne, have identical climate, social, economic and dietetic conditions, the only difference being that South Shields' water supply contained 1.4 p.p.m. fluoride, whilst North Shields' water contained negligible fluoride (0.025 p.p.m.)[24]. The designation DMF (decayed, missing, filled) has been used as an index of the frequency of dental caries. In America, the DMF rate per 100 teeth of school children at a specified age was determined for children at Newburgh, New York. After the introduction of 1 p.p.m. fluoride to the drinking water, the DMF rate dropped over a period of years by more than 50%. Kingston, with a water supply containing negligible fluoride, was chosen as a control and in fact showed a slight increase in DMF

rate during the same period. The results of these and other extensive studies in the United States, Canada and Russia produce striking evidence of the efficiency of reducing dental caries by fluoridation of water supplies deficient in natural fluoride.

The Fluoride Problem.

It has been shown conclusively that a concentration of 1 p.p.m. fluorine in the drinking water is effective in reducing the onslaught of dental caries. Higher concentrations in children produce the motled enamel characteristic of endemic fluorosis, and yet higher concentrations produce very brittle teeth which are easily chipped and abraded. How does one explain these findings? It is not known for certain how 1 p.p.m. fluoride in the water inhibits caries. One theory is that fluoride inhibits the lactobacilli which promote caries by producing lactic acid from particles of carbohydrate adhering to the teeth. The acid dissolves away the hydroxyapatite and the organic tooth structure is laid open to the ravages of proteolytic microorganisms which complete the destruction of the tooth. However, in vitro at least, a much higher fluoride concentration has been shown to be required to inhibit lactic acid production than would normally be present in the mouth. The other theory is that fluoride acting locally in the mouth decreases the solubility of the enamel. Hydroxyapatite has considerable adsorptive properties and small ions such as Mg^{++}, Na^{+}, F^{-}, besides Ca^{++} and PO_4^{---}, are adsorbed onto crystals of the substance. It is therefore feasible that practically insoluble calcium fluoride forms a protective layer on the surface of the tooth, viz:—



The absorbed ions are not part of the fundamental structure of hydroxyapatite and are therefore continuously being removed. Hence the need for an adequate supply of fluoride throughout life to ensure that the calcium fluoride layer is always being re-formed. But when there are large amounts of fluorine present in drinking water, what is not excreted in the urine is laid down in bones and teeth, and fluorine displaces the hydroxyl ions in hydroxyapatite to form fluorapatite, a reaction which may be represented as—

$$Ca_3(PO_4)_2.Ca^{++}2(OH^-)+2F^-=Ca_3(PO_4)_2.Ca^{++}2F^-+2(OH^-)$$

and, as stated previously, teeth with a high proportion of fluorapatite are brittle and easily damaged.

Just as an optimum amount of fluorine is required for sound, healthy teeth, so does it also prevent osteoporosis. Increased bone density was the principal finding in cases of endemic fluorosis, fluorapatite having a greater density than hydroxyapatite. In the light of this a few investigators have successfully treated patients suffering from osteoporosis with sodium fluoride. The result was recalcification of the skeleton, reduction of urinary calcium excretion, and initiation of a mild positive calcium balance. A recent survey was carried out in high and low fluoride areas in North Dakota on subjects over 45[25]. The high fluoride area contained 4—5.8 p.p.m. and the low fluoride area 0.15—0.3 p.p.m. in the drinking water. Evidence of osteoporosis, reduced bone density and collapsed vertebrae was substantially higher in the low fluoride area, and there was also a higher incidence of calcification of the aorta. It would appear, therefore, that small quantities of fluorine are necessary for normal bone metabolism, and, by binding the dietary calcium into bone, play a preventive role in the calcification of soft tissues, and in particular the hardening of arteries.

What then is the fluoride problem? In Great Britain, foodstuffs contain only small amounts of fluorine, e.g. flour 0.5—0.8 p.p.m., eggs 0.3 p.p.m., corned beef 0.4 p.p.m. Sea foods contain slightly higher amounts, e.g. pilchards 5.8 p.p.m. and shrimps 2.4 p.p.m.[26]. Substances such as baking powders, 70 pp.m., and tea leaves 120 p.p.m., are ingested only in comparatively small quantities. Similarly, the quantities of leafy vegetables containing fluorine eaten by normal persons are comparatively small as compared with the amounts ingested by herbivorous animals, and this explains why in outbreaks of industrial fluorosis livestock was affected far more than human beings living on the same farms. Milk and meat from fluorotic cattle has practically the same fluorine content as that from normal cattle. However, industrial food manufacture poses certain problems, especially where coal is burnt as fuel, and a classic example is the brewing of beer. British coals contain from 5—200 p.p.m. fluorine, mostly present as apatite. In a direct contact type of kiln, practically all the fluorine in malting coal passes onto the malt in the combustion gases, and thus coals contribute fluorine to beer in the same way as they could contribute arsenic. Hence the need for careful selection of malting coals with a low fluorine content, and most British beers, e.g. pale ale, brown, and stout, contain 0.6 p.p.m.[27]. Before fluorosis

was known to exist, many American imported beers contained well over 1 p.p.m. fluorine, a few as much as 40 p.p.m. The latter had probably been manufactured by a process which included the deliberate addition of a fluoride to retard fermentation.

By and large, therefore, the major source of body fluorine is in the water supply. The fluorine of the world is unevenly distributed geologically, so that some people find too much in their water supply, and others not enough. The optimum value appears to be 1 p.p.m. fluorine; populations with this amount have signficantly healthier teeth and bones, all other factors being constant. Industrial and occupational fluorosis can be avoided by taking the necessary precautions. For example, suction removal and electrostatic dust precipitators in cryolite factories prevent aspiration of fluoride particles, and common sense is all that is required in chemical industries. In populous regions low-apatite coal could be used for combustion, thus reducing the risk of pollution from hydrogen fluoride and silicon tetrafluoride. An effective method for "scrubbing" waste gases from combustion has yet to be found. Chronic endemic fluorosis can be, and has been, reduced by the establishment of a fluorine-reduced water supply and the closure of local wells. Water supplies deficient in fluorine can be made up to the optimum value of 1 p.p.m. There has been a great deal of controversy over the ethics of adding fluoride to water, mostly by people in ignorance of the full story. This form of preventive medicine is no different from adding iodide to table salt, vitamins to bread, or even immunisation. These are measures which improve the health of the community, and prevention is always better than cure.

ACKNOWLEDGMENTS.

The author wishes to thank the following gentlemen for their part in the production of this paper:—

Dr. Edgar Crossley, of the Central Electricity Generating Board, Research and Development Department, for being the instigation behind the paper and for introducing me to the literature;

Mr. David Cawsey, of the University of Swansea, for his invaluable assistance in the geological aspects of the subject;

Professor G. A. D. Haslewood, of Guy's Hospital Biochemistry Department, for his advice and assistance, and for acting as chairman for the presentation of the paper before the Physiological Society;

My fellow 2nd M.B. students of Guy's Hospital for their stimulating suggestions; and, above all,

Mr. L. H. W. Savage, for his able advice and encouragement, without whom this paper would not have been possible.

REFERENCES.

1. Special Report on the Mineral Resources of Great Britain. Geological Survey. Vol. IV Fluorspar. 4th Edition, 1952.
2. Carnot, M. Ann. Min. Paris. ser 9 vol. III (1893) 155.
3. Bromehead, C. Trans. S.E. Union Sc. Soc. Presidential Address. July, 1943.
4. Goldschmidt, V.M. Geochemistry.
5. Cummings, W. G. The Occurrence of Fluorine and its effect on plants, animals and human beings: a review of published work. Central Electricity Research Laboratories. Lab. Rep. 501.

6. Lidbeck, W. L. et al. Acute Sodium Fluoride Poisoning. Journ. Am. Med. Ass. 121 (1943) 826.
7. Griebel, C. et al. Z. Pntersuch. Lebensmitt. 75 (1938) 305.
8. Roholm, K. Fluoride Intoxication. (1937).
9. Roholm, K. Arch. wiss. prakt. Tierheilk. 67 (1934) 420.
10. Bosworth et al. Discussion of Fluorosis in Man and Animals. Proc. Roy. Soc. Med XXXIV (1941) 391.
11. Green. An outbreak of industrial fluorosis in cattle. Proc. Roy Soc. Med. XXXIX (1946) 795.
12. Singh, A. et al. Skeletal Fluorosis and its Neurological Complications. Lancet i (1961) 197.
13. Okerse, T. Endemic Fluorosis in the Pretoria District. S. Afr. Med. Journ. July 1941.
14. See 10.
15. Velu, H. Arch. Inst. Pasteur Alger. 10 (1932) 41.
16. Ainsworth, N. J. Brit. Dent. Journ. 55 (1933) 233.
17. Kumar, S. P. et al. Brit. Journ. Radiol. 36 (1963) 497.
18. Medical Research Council Memo. No. 22. Industrial Fluorosis. London. H.M.S.O. (1949).
19. Goldemberg, L. Semana Med. 28 (1921) 628.
20. Pighini, G. Il gozzo endemico e la sua etiologia, in: funzioni e disfunzioni tiroidee. Institut Sieroterapico, Milan. (1923).
21. Wilson, D. Fluorine in the Aetiology of Endemic Goitre. Lancet i (1941) 211.
22. Ainsworth, N. J. Analyst. 59 (1934) 380.
23. King, J. D. Spec. Rep. Ser. Med. Res. Council. London. No. 241 H.M.S.O. (1940).
24. Gordon Carey, W. Water and Public Health. 28th Streatfield Memorial Lecture, Nov. 1945. Roy. Inst. Chem.
25. Prevalence of osteoporosis in high and low fluoride areas in North Dakota. Journ. Am. Med. Ass. 198 (1966) 5.
26. Rep. of Analysis Sub-Committee of Public Analysts. Analyst 69 (1944) 243.
27. Crossley, H. E. Fluorine in Coal. IV. The industrial signficance of fluorine in coal, in steam raising, gas making and brewing. Journ. Soc. Chem. Ind. LXIII (1944) 342.

Obiter Dicta

Delivered hear
by mistake

With the
Compliments of the
Education Officer

The County Hall
London, SE1
WATerloo 5000. Ext

REPORTS

ANNUAL DENTAL CLINICAL MEETING

March 4th, 1967.

As is customary on this nostalgic occasion, approximately three hundred graduates converged on the Dental School for the annual reunion. Although the flow was slowed by unexpected alterations in the car parking routine due to the tower block scheme, by mid-morning many small groups of identifiable dentists were scattered throughout the ramifications of the School avidly discussing dental and social topics.

Evidently these personal contacts and the combined effect of the various operations, clinics and table demonstrations consequently discouraged many people from attending the morning paper. This concerned the three-year clinical assessment of Fluoride-containing Toothpastes by Dr. M. N. Naylor. However, those who managed to break away were soon interested in a well presented, lively lecture. Although the final results from the trial were not available for presentation, it seems evident that fluoride toothpastes are a useful dental health measure.

Obviously it is difficult to comment on the whole programme in detail when compiling a brief review of the various presentations, but it is easy to complement the visual aid departments on their contribution to the effectiveness of many of the exhibits. The Medical Illustration and Dental Photographic Departments were largely responsible for the high standard of many of the demonstrations. One which was particularly eye-catching was to be seen in Dental Medicine showing the effects of carbohydrate diets on caries in rats. Nevertheless, there was a noticeable desire amongst the audiences to make verbal contacts with exhibitors however self-explanatory the visual material may have appeared to be.

Now that the staff of the School are constantly assessing the effectiveness of their teaching programmes a number of departmental film units have developed and it was possible to compare some of the results produced by the Children's Department, Department of Conservative Dental Surgery and the Prosthetic Department. It was immediately obvious that different subjects require various methods of presentation. Delicate procedures such as cavity preparation are shown more effectively by using a 16 mm. film, whereas techniques requiring less detailed presentation can be shown on 8 mm. film.

A trend which has become more apparent in recent years towards an increasing interest in the commercial value of the exhibits, now seems to have become established. This year, it was to be found in association with subjects such as Denture Cleansers and Disposable Equipment in Dentistry. The value of Dental Hygienists was also made apparent by a visit to the Department of Preventive Dentistry where some effective propaganda material on dental health education was displayed.

Research topics do not always have an immediate appeal to the casual oberver but immune factors in caries compel some attention and preliminary findings were presented in the Department of Dental Medicine and Conservation Department. These help in postulating a link between caries prone patients who are susceptible to a comparatively slight intake of refined carbohydrate.

As usual, the Children's Department was busy all day with a variety of practical exhibits and on overhearing the remark by one of the Staff that "They all bring up their little boxes" one can soon estimate their practical value in orthodontic practice. A greater emphasis has now been placed on the teaching of pedodontics in the Department and a most comprehensive demonstration on the treatment of the fractured maxillary incisor was shown.

Since the last Clinical Meeting a Department of Oral Surgery has been established and was presenting a comprehensive exhibit displaying a considerable

array of instruments which we were assured were in current use. It was unfortunate that the instruments used during the actual operating sessions were not so readily visible owing to theatres with observation domes being unavailable at the time.

The Tower Block plans being complete it was possible to display the judgment of the planning committee. This small group have had a difficult and time-consuming task and as far as can be ascertained without examining the completed structure, have accomplished a promising plan. Contemplating the commencement of the building and envisaging the environment when it is finished seemed to be a most pleasant pastime, especially for those who might have some reasonable expectation of seeing the results.

The afternoon lecture for so long popularised by Professor M. A. Rushton, saw the dental lecture theatre full to overflowing by those anxious to hear his successor, Professor R. A. Cawson, who used the title "Cases you have sent". This could have been more reasonably entitled "Cases I have assembled for your entertainment". Ranging widely, from the gradual discovery of a large piece of shrapnel in a patient's cheek, to the rapid awareness of the more intimate of acquiring of hand, foot and mouth disease by dental nurses, students and staff, this was a well rehearsed performance and very popular with the audience.

During the evening three hundred and twenty graduates and guests sat down to a sumptuous Dental Society Dinner at the Park Lane Hotel. The traditional speeches were given and a particularly enthusiastic response awaited Professor W. E. Herbert, who entertained the company whilst proposing a toast to the guests.

Last impressions of the day are difficult to define but it was felt to be a particularly happy occasion with a feeling of euphoria which could well be due to the long-awaited rebuilding of the Dental School, which almost seems a practical reality.

D. LONDON.

Music Club Concert—March 17th, 1967

The medieval architecture of Southwark, with its high arched windows and decorated nave, made a suitably austere setting for Vivaldi's Gloria, a work written around 1700. It was a great pity that more people didn't attend. Perhaps the bizarre range of composers in the first half of the concert put them off (or perhaps there is a stronger Irish contingent in the hospital than one realises).

Those who did would have enjoyed the vital and enthusiastic performance of the work given by Guy's Hospital Orchestra and Choirs, directed by Stephen Coles. The difficult choral writing (for singers really of virtuoso standard!) was made to sound exciting by its accuracy of intonation and where necessary, its lightners. The range of volume obtained showed the extremely careful preparation that the conductor had carried out: how delightful it was to hear such good piannissimo! One may not agree with the use of counter-tenors, but John Dudley made out as strong a case as possible—his cadenza being a high spot of the performance. Our orchestra provided a crisp and incisive accompaniment, especially as the work progressed. We clearly owe much to the new conductor, who must be considered an exciting prospect, so long as he keeps to conducting rather than trying to sing counter-tenor!

In the first half, Hilary Jane Groves had sung three Bach songs—she excelled in the colouration writing but was less happy with the songs of comfort. Cantatas by Buxtelunde and Humfrew made rare appearances (fortunately they rapidly disappeared as far as I was concerned!) Rather more interesting was a work by Jim of London (Loeillet) performed by Jennifer Thompson (flute) and Michael Coe (Oboe) with continuo: this at least brought some really needed brio and panache to an otherwise dull half hour's music.

I sincerely hope Mr. Coles and his fine forces can be persuaded to put on a work by Mozart or Haydn: I feel sure this would not only be enjoyable to work on but would undoubtedly attract a larger audience: this group are clearly capable of great things.

HEDLEY BERRY

REVIEWS

THE DEAF CHILD

by E. Whetnall and D. B. Fry. Heinemann, London, 1964. 1st Edition. Pp. 237. *Price* 42*s*.

Edith Whetnall is the Director of the Nuffield Speech and Hearing Centre at the Royal National Throat, Nose and Ear Hospital. She has won international recognition as an otologist who for the past 20 years has devoted herself to audiology, with special reference to the early diagnosis and training of young children with impaired hearing. Denis Fry, who is now Professor of Phonetics at University College, has worked in collaboration with her from the beginning.

This book brings their joint findings and views up to date. It is intended mainly for readers with medical knowledge and is concerned with aetiology, assessment, auditory training and the basic principles of phonetics and linguistics in relation to very young children and those who are able, with special help, to attend normal schools. It does not attempt to discuss language disorders other than those due to impaired hearing, nor does it venture into the field of education in schools for the deaf. Within these self-imposed limits the book is a very useful one. The literary expression is beautifully clear and there are numerous attractive photographs showing the clinical testing and auditory training of young deaf children. There is an up-to-date reference list and a good index. Every medical student, paediatrician, and otologist will profit from reading it.

M. SHERIDAN

REVIEW OF OPERATING ROOM MANUAL (2nd Edition).

Mary Ellen Yeager, R.N., Supervisor of Operating Rooms and Recovery Room of the City Hospital Centre at Elmshurst, New York.

Part I of this book deals with the general function of the nurse in the operating room, sterilisation of instruments and supplies and the routine maintenance and procedures in any operating theatre. This is an excellent summary which, in the most part, could well be applied to modern practice in this country. The principles of sterilisation quoted must be excepted from this as they differ somewhat from modern practice in Great Britain. Other details might not find universal acceptance, i.e. an operating theatre temperature of 78° F. would, in our opinion, be too hot.

The 11 other sections in the book deal with different branches of surgery. In each case, the theatre furniture, packs and general method of skin preparation are detailed. This is followed by a description of the position of the patient on the operating table. Details of the instruments, needles and sutures are given, and the lists of instruments are most helpfully illustrated by line drawings. In this country, little attempt has been made to standardize instruments, needles and sutures in a given hospital, let alone a group of hospitals. This information must simply serve, therefore, as a basis for comparison, and only those sections which are found strictly applicable to our practice accepted.

This book is a most comprehensive attempt to compile an operating room manual. Much of the information contained in it is of value to all of us, and every theatre superintendent will find it a most useful book of reference.

MARGARET LAWS.

AN ATLAS OF HISTOLOGY.

By Freeman and Bracegirdle. Heinemann. 140 pp. 95 figs. *Price* 30*s*.

The purpose of this book is to provide an aid in the laboratory interpretation of histological preparations and is intended for "A" level and first degree students. As such, it is only just adequate in general, though in small sections, e.g. the ear, it seems to be in exaggerated detail. For a medical student it covers no more than first M.B. work.

The book is well designed and beautifully illustrated throughout with excellent photographs of carefully selected and often specially prepared sections. The line drawings of each slide are well executed, but the labelling is poor. The drawings of the cochlea in particular have a Gordion knot of crooked pointers beyond untangling without mechanical aid.

Several tables give a good summary of the characteristics to help in identifying tissues or organs. On the whole, this is a good concise book, but expensive for what it offers and of little use beyond first M.B. The scope is too narrow. It is neither a complete atlas nor a complete textbook of histology.

A. M. MORRIS.

CORRESPONDENCE

Dr. Evans in Vietnam

The following letter was recently received by the Secretary of the Music Club and is printed here at Dr. Evans' wish.

Dear Mr. Coe,

Thank you for your letter telling me about the Concert given by members of the Musical Club in Southwark Cathedral on December 7th. This was a fine performance. I have heard from a member of the audience how moving the Christmas music was. It was also a fine effort financially; we shall be glad of that £50.

How shall we use it? I don't know yet. We get good support for medical expenses from the Ministry of Health in Saigon as well as from the Ministry of Overseas Development in London, but there are gaps. For example, many drugs can not be got from the hospital pharmacy, so mothers are expected to go out and buy them from chemists in the town—if they can afford it. Sometimes they can't, so we are able to help. Other mothers have left home and a job to go into hospital with their children; the children get hospital food but the mothers have to buy their own and they may have no money. The nurses are usually too busy (e.g. giving blood transfusions, injections and medicines, or keeping records) to feed, change or wash the children; sometimes a mother of five may have to stay at home and pay someone to look after the one child in hospital, again if she can afford it. We have also used money we have been given for buying towels, paper napkins, children's potties, spittoons, antiseptic, wall paint, wire wool, soap, a prototype hospital locker and 48 packets of Farex.

With best wishes to all at Guy's.

Yours sincerely,

PHILIP EVANS

P.S.—Only the first 100 ml. of blood is provided free for a transfusion, after that it costs one piastre (about a penny) a ml.

Hallett Prize

SIR,—I am sure it is worthy of publication in your pages to state that the Hallett prize, awarded for the top student in the Primary Fellowship examination, was on the last occasion shared by Mr. C. G. C. Gaches. It is a long time since the same award was made to anyone in this Medical School; in fact, we understand that the last recipient was Professor Hedley Atkins in 1930. We are sure that all our friends and colleagues at Guy's will join us in warm congratulations to Mr. Gaches. We trust this is a signal of marked success in his future career.

Yours, etc.,

ROGER WARWICK,
Anatomy Department
WALTER H. H. MERIVALE,
Department of Clinical Pathology

Guy's Hospital Medical School.

[EDS.—*In fact Mr. (now Professor) Roy Yorke Calne was a Guy's man who won the Prize in June* 1957.]

Doris Chrimes

SIR,—May I through the *Gazette* express my very great thanks to the many kind friends who signed my "Leaving Book" and also gave me such a generous gift. This book, and the things which I hope to buy with the gift money, will always be a source of great pleasure to me.

They will often bring to my mind many pleasant memories of delightful people.

Yours, etc.,

DORIS CHRIMES

170, Kennington Park Road,
S.E.11.

Where there's smoke . . .

SIR,—As an Englishman very much aware of the existence of apartheid, I should like to express my disgust at the Sports Editor's contribution to the *Gazette* dated 18th February, 1967.

Something is surely amiss when our Sports Editor finds it necessary to relegate Hospital Sport to "News in Brief", and to indulge in bigoted and unnecessary comment on an issue which happily does not involve our own sporting activities. May I suggest that in future he reserves this sort of bitter criticism for the National Press, or resign from his post of Sports Editor in favour of someone who can write about sport at Guy's.

Yours, etc.,

L. J. TURNER

East Wing,
Guy's Hospital.

Problems Uncommon and Common

SIR,—When is the *Gazette* going to publish an appreciation of Prof. M. A. Rushton—or do consultants have to die first!

Also, there was no announcement of Nigel James' appointment as Consultant Dental Surgeon at the Leicester Royal Infirmary—this was over 18 months ago.

The *Gazette*, as usual, is excellent, but still overpowering in its medical aspects of hospital life, including articles.

Yours, etc.,

MARTIN GAIN

34, Station Road,
Hinokley, Leicester.

[EDS.—*For Prof. Rushton's appreciation see* Gazette *17th September*, 1966. *Regarding news of Mr. James' appointment—unfortunately the above is still one of the most frequent forms of such information reaching us, in spite of appeals in Passim. Point three: As we receive, so shall we consider for publication, irrespective of source.*]

NURSING SECTION

Those Dreaded Results

As this article goes to Press there will be about 6,000 new State Registered Nurses in this country.

A few of the candidates who passed will have taken the examination for the second time, and a number who sat this time will be taking the exam again at the next sitting.

Nurses who are State Registered can remember vividly their own Finals and probably a number of them may stop to consider the machinery involved in the General Nursing Council examination system.

At present each hospital entering candidates for their State Finals has to submit two reports about each candidate to the G.N.C. The first report to say that she has attended the requisite number of lectures in her School of Nursing, and the second to verify that she has worked in those wards and gained experience in the types of nursing necessary for State Registration. The candidate then sits two three-hour papers—generally in her own hospital, and then has a one-hour practical examination, usually one week after the written papers and quite often at a hospital away from her own. The examiners for the written papers are a group of doctors and nurses and for the practical exam, two G.N.C. examiners who in the main are experienced Nurse Tutors and Ward Sisters.

These methods mean that a nurse is examined in her theoretical attainments and in practical work in the situation as it is presented to her under the stress and tension of the moment.

All systems are unfair in one way or another. In the G.N.C. method of examination candidates are at present examined out of the ward situation. Many who enter are subjected to paralytic pre-examination nerves (with no patient to help) and although otherwise very good nurses they perform badly or even fail in their practical examinations. Similarly those nurses who are a poor average in their own hospitals' day-to-day work, manage to bluff their way through their State Final examinations.

Personalties are always involved in any system of examination. Those people who have to assess reports will tell you that the personality of the person making the report is usually more obvious than that of the subject of the report.

The question arises as to whether nurses would be more adequately tested if a precis of the marks they have gained in their own hospital examinations throughout training, in conjunction with a precis of their ward reports were taken into account when totalling the Final examination results.

Some nurses may think that this is unfair and that they would prefer to be well away from their training hospital at time of examination; others might feel that their training attainments would favourably prejudice their Final results.

The system of examination is constantly under review and there have been a number of changes recently. The theoretical examination was last implemented in June 1966 when the questions were printed with percentage marks to be alloted alongside each part of the question, and the practical test was last changed three to four years ago when a case project was used at the beginning of the examination.

Nurses who attempt the Final State Examination can rest assured that the whole system is under constant surviellance but that there is always an element of luck attached to the results given by the examiners that they meet.

STAFF CHANGES AND APPOINTMENTS

NEW APPOINTMENTS

Sister M. Boswell, S.R.N., R.S.C.N. (Miller General Hospital, Greenwich), to the Evelina Hospital.

Sister R. G. Selway, S.R.N. (Guy's 1960—1964), to Cornelius Ward.

S/N E. Allen (Royal Sussex County Hospital), to Theatres.

S/N C. Evans (The Middlesex Hospital), to Nuffield B Floor.

S/N E. F. Heaton (Dunedin Hospital, N.Z.), to York Clinic.

S/N D. Larbelesteir (Guy's 1961—1964), to Dorcas Ward.

S/N E. K. Nilsson (St. Birgitta's School for Nurses, Sweden), to Barnabas Ward.

DEPARTURES

Sister M. Atkinson, from Cornelius Ward.

Sister B. Wooley, from Midwifery Unit.

S/N C. D. Barnes, from Lydia Ward.

S/N V. Bayes, from Evelyn Ward.

S/N R. Beattie, from Diplock Ward.

S/N C. M. Davies, from Bright Ward.

S/N J. Dimond, from Diplock Ward.

S/N E. A. Dow, from Surgical X-Ray.

S/N M. J. Finlay, from Bright Ward.

S/N J. Fleming, from Miriam Ward.

S/N B. Houghton, from York Clinic.

S/M J. O'Flynn, from Victoria Ward.

S/N A. K. Roger, from Outpatients Dept.

S/N L. Sheppard, from Evelyn Ward.

S/N L. Sirot-Smith, from Radiotherapy Department.

SPORT

SOCCER

Thwarted, Guy's were defeated 2—1 by The London in the United Hospitals' Cup, exhibiting a performance well below their best. Melancholic they lean against the bar—at least possessing the League Championship.

RUGBY FOOTBALL

Following a change of rendezvous and also date, Guy's "A" XV played the Final of the Junior Hospitals' Cup on Tuesday, 21st March, at Honor Oak Park.

True to form, Guy's teased the touch-line supporters with an "in-the-balance" game producing great excitement and suspense (and even at times good rugby). Davies, consistently kicking well, highlighted the game by kicking the winning penalty from in front of the posts in the last few minutes. It was with frank amazement that Turner was sent off, having been caught hacking at a London player on the Guy's line—Turner was not however the primary offender. Although the correct decision, it seemed that the over-enthusiastic crowd (predominantly Guy's) shouting "off" with reference to the first offender—a London player—might have prompted and even escalated the situation.

After a somewhat insipid season that produced a long spell of losses, it is ironic that the "A" XV should win the Hospitals' Cup.

When Guy's were entertained at Gloucester they were most generously and elequently welcomed by a Guy's Vice-President of the Rugger Club and for 43 years President of Gloucester R.F.C.—Mr. Arnold "Doc" Alcock. Gloucester, feeling that Guy's "sprang a surprise by defeating Gloucester 12—5 last year", were rather deflated when again Guy's won by a penalty (by Elliott) and a fine try (by Osbourne) to a try by Gloucester.

It is more than appropriate that we note that "Doc" Alcock (no apparent relationship to Benjamin Alcock of Alcock's Canal) played for Guy's 1903-1907. On gaining an English Cap for 1906-1907 season, the *Gazette*—Vol. XX, No. 482, December 15th, 1906—reported the following:—

" . . . Mr. Alcock, who has played extremely well all through the season, both for Guy's Hospital and for Surrey County, attracted the eye of the English selection committee when Surrey played Kent. Since then he has been selected to play in the trial match for the Rest of England, when he played a fine game. He was chosen as one of the English forwards in last Saturday's match against the South Africans at Crystal Palace . . . His selection is the more gratifying to Guy's men because he has never played for any "outside" club—which shows that it is possible to get an English Cap without playing for Richmond or Blackheath."

"Et touché"—a Scottish Cap?

Commencing April 3rd, Guy's R.F.C. will be on tour in Lancashire. We hope that Guy's men resident in Lancashire will support the games against Fylde (April 3rd), Waterloo (April 4th) and Vale of Lune (April 6th)—all are evening games.

HOCKEY

Guy's in the London University Six-a-side competition on March 23rd, having defeated Chelsea, The L.S.E. and College of Estate Management, reached the semi-final only to be beaten by St. Mary's, who later succumbed to University College, the eventual winners.

DIARY

RUGBY:

April 1st.—O. Whitgiftians. Away.
April 3rd.—Fylde. }
April 4th.—Waterloo. } Lancashire Tour.
April 5th.—Vale of Lune. }
April 8th.—Tredegar. M.O.P.

RUGBY FOOTBALL

GUY'S v. ST. ANDREW'S UNIVERSITY

Wednesday, 22nd March, 1967

Result: won 36—0

In spite of the convincing score line, Guy's made heavy weather of winning this match against a touring side from St. Andrew's University, consisting of slightly more than half their usual first team.

The firt half ended with the score 5—0, due to an interception by J. E. Davies when St. Andrew's tried to pass on their own line. Although there was a strong wind blowing into Guy's faces during the first half, they should have been winning far more easily. Guy's were doing well in the tight. They won the majority of line-outs, and in the tight scrum they won heels against the head 22—1. In consequence St. Andrew's were continually defending, and never had a chance to use the wind to gain ground. The number of wasted chances by bad passing and over-complicated movements was incredable. In fact, Guy's could count themselves lucky to be in the lead at half-time. They had two tries disallowed, one by Ross and one by the forwards, for being in touch, but this did not excuse them for their poor play.

After the interval the side had perked up a bit. The backs were more coherent, and the loose work by the forwards an improvement. The first score was a pushover try, credited to Neville. Elliott converted this, as he had the first try; he scored next with a 30 yard penalty. Swift made the next try with a pass to Ross on the blind-side from a loose scrum ten yards out. Ross ran to the corner, cut inside the full-back and ran under the posts, for another converted try. Ross was held up on the line twice more after very good runs.

However, the St. Andrew's fly-half moved to the wing because of a shoulder injury, while one of their centres came off with a fractured fibula. The Guy's pack were completely dominant in tight and loose over St. Andrew's pack from then on.

Rowlands and Beacham made the next try from the half-way line with some good inter-passing plus a side step from each for Rowlands to score; again converted by Elliott. Thorburn then scored twice, taking a pass from Kingdon for the first . Elliott converted the first of these.

Finally, J. E. Davies scored a second try, to the huge acclaim of the vast assembly of 40 spectators.

Generally, Guy's were fair value for money. Elliott was adequate in the centre, his deputy, W. W. Davies, at full-back had little to do, and looked very cold doing it. A Fallowfield played well at wing-forward, the other newcomer, Logan, being rather inconspicuous, but the experts were fairly complimentary about his play at tight head prop.

Guy's: W. Davies; J. Ross, D. Elliott, D. Osborne, R. Beacham; B. Rowlands, P. Swift; J. Logan, G. Hey, J. Davies, A. Kingdon, M. Cockburn, A. Fallowfield, C. Neville, C. Thorburn.

I. M. MORRIS

GUY'S v. DEVONPORT SERVICES

Saturday, 28th January, 1967

Result: won 22—12

This was the first fixture between the two sides for at least two seasons, the encounters in the meantime having been cancelled due to adverse playing conditions. This match might well have suffered the same fate had our hosts not chosen to open the new extension to their clubhouse on this particular afternoon, for the pitch was a sea of mud after three days of continuous rain.

Guy's kicked off into the wind, and it soon became obvious that the best tactics would be to keep the ball close in the forwards until within striking distance of the opponents' line. These tactics soon brought rewards; first Price crossed for a try after a good loose heel and then Thorburn was credited with a pushover try under the posts. Elliott converted the latter, and also landed an easy penalty goal. Guy's, at this point, predictably relaxed and allowed Devonport to come back into the game, their half-back kicking well to gain ground and exploit defensive weaknesses. The lead was soon reduced when Guy's centres trespassed into "no-mans-land" at a line-out in their own "25", and they were justly penalized for their indiscretion. Further scores came when the home side took advantage of two bad defensive errors, but fortunately neither try was converted.

Half-time: Devonport S. 9; Guy's 11

After the interval, Guy's regained some of their poise and by making good use of the prevailing wind and wet ball spent long periods in their opponents territory. The back-row of Thorburn, Curzon and Sharp were particularly effective, harrassing the Devonport half-backs into many mistakes and then taking the ball on at their feet. The home side's reluctance to drop on the ball in these circumstances led to tries by Osborne and Sharp. The Services replied with a penalty after an infringement in a loose maul. During the last quarter, Guy's tried a great variety of moves, but failed to score until just prior to no-side, when Curzon scored a try after good work by Swift down the blind-side. Osborne converted. They might have profited more if short chip and grubber kicks had been used instead of ill-directed diagonals and moves that were more suited to dry conditions.

B. J. ROWLANDS

Sports Ed.—Easter has precipitated a premature "going-to-press" of the "Gazette". We apologise for the sparse number of reports.

HOSPITAL INFORMATION

APPOINTMENTS VACANT

GUY'S HOSPITAL, S.E.1.

Applications are invited for the post of **temporary Registrar in Paediatrics at the Evelina Children's Hospital of Guy's Hospital.** Duties to commence as soon as possible, and appointment until 30th September, 1967. Forms of application are obtainable from the Superintendent, Guy's Hospital, S.E.1, and should be returned not later than **10th April, 1967.**

GUY'S HOSPITAL DENTAL SCHOOL

Applications are invited for the following appointments, to commence duties on 1st October, 1967:

Senior Lecturer (full-time) in the Department of Conservative Dental Surgery; salary in the scale £2,315 x £110 to £2,755 (bar); £2,865 x £110 to £3,085 with superannuation (subject to review);

Lecturer (full-time in the Department of Conservative Dental Surgery; salary in the scale £1,580 x £110 to £1,690 x £115 to £2,150 x £110 to £2,480 x £55 to £2,535 with superannuation (subject to review).

Forms of application are available from, and hould be lodged with, the Dean, Guy's Hospital Dental School, London, S.E.1, not later than **Monday, 24th April, 1967.**

GUY'S HOSPITAL, S.E.1.

Applications are invited for the following appointments to commence on 1st October, 1967:

Department of Conservative Dental Surgery
Registrars to attend full-time or part-time.

Department of Dental Prosthetics
Registrars to attend on six, five, four, or three sessions per week.

Dental Department for Children
Senior Registrar to attend full-time.
Registrar to attend on six sessions per week.
Orthodontic Assistant to attend on six sessions per week (Registrar grade).

Clinical Dental Surgery including Oral Surgery
Senior Registrars/Registrars to attend full-time.

Department of Preventive Dentistry
Registrars to attend on six, five, or three sessions per week.

Casualty Department
Registrars to attend on six or five sessions per week.

Minor Oral Surgery Department
Registrars to attend on six or three sessions per week.

Dental Radiology Department
Registrars to attend on six, five, or three sessions per week.

Dental Officer to treat In-Patients
One Dental Officer to attend on six sessions per week.

Forms of application are obtainable from, and should be lodged with, the Superintendent, Guy's Hospital, London, S.E.1, not later than **Monday, 24th April, 1967.**

GUY'S HOSPITAL, S.E.1.

Applications are invited for the appointment of **Trainee Registrar in the Department of Diagnostic Radiology,** with duties from 1st October, 1967. Appointment for one year in the first instance. Forms of application are obtainable from, and should be lodged with the Superintendent, Guy's Hospital, S.E.1, not later than **17th April, 1967.**

PERSONAL

DENTAL ASSISTANT with view to partnership required in conservative three-man practice in Eastbourne. Tel. Eastbourne 30406.

TWO GUY'S DOCTORS find General Practice interesting. Duty rota. Appointment system. Ancillary help. Third Partner required to share their interest. Details from Drs. Bush and Muir, Hayesbank, Canterbury Road, Ahford, Kent. Telephone Ashford 1675.

ASSOCIATE/ASSISTANT required from 1st May in South London. Usual clinical freedom, surgery assistance and percentage remuneration. Tel. Pol. 4340.

TO LET—Georgian Cottage in village near Exeter. Fully modernised, fully furnished. Sleeps six. All electric. Details, Mrs. H. M. Aggett, Ext. 486.

BROADSTAIRS, Kent. Comfortable furnished house to let in quiet road. Three bedrooms, sleep five. Also baby's cot. Near sea and shops. Garage. Apply, 21, Orchard Road, Sidcup, Kent.

BIRTH

CARROLL—On 18th February, 1967, at St. Teresa's, to Judith (née Gibson) and Desmond Carroll, M.D., M.R.C.P., a daughter, Mary Imelda Síobhan.

MARRIAGE

BOGER—FOLBIGG—On 10th November, 1965, at All Saints, Hunter's Hill, New South Wales, John Boger to Benita Folbigg.

DEATHS

COURT—Philip Francis Shelsley, M.R.C.S., L.R.C.P., F.R.C.S.Ed. On 7th March, 1967, while on holiday in Durban, South Africa. Aged 66.

WATTS—On March 4th, 1967, Gina, aged 2½ years, daughter of Crystal (née Thomas) and Michael Watts, of Bury St. Edmunds.

We would like to remind our readers that all copy for inclusion in the Gazette must be received eight days before the publication date.

Personal notices one shilling per word (Minimum £1. 1s. 0d.)
Birth, Marriage, Death and Change of Address notices are without charge to subscribers.
Non-subscribers will pay £1. 1s. 0d. for all notices other than Personal.

GUY'S HOSPITAL GAZETTE

EDITORS D. S. ROBINS and C. B. BROWN
SPORTS CORRESPONDENT J. G. PAYNE
NURSING CORRESPONDENT E. A. MALPAS

FORTNIGHTLY TWO SHILLINGS VOLUME 81 NUMBER 2054

The opinions expressed in these columns are solely those of their authors and are not to be taken as the views of the Hospital as a whole.

PASSIM

Spring Neurosis

Season of skis and sundrenched beaches. The Englishman on Spring holiday: nursery slopes, suntan oil, waving to other G.B's. on the road, vino, and the mad dogs left unwillingly at home. Well-stocked as a result of the good advice of aunts and tele adverts, with his remedies and patent medicines, guarantees for journey and holiday comfort: "Is it safe to take a Kwell after I've had a lager? I know it's dangerous with aspirin." Popular medicine finds its market: the little Dr. Kildare that lurks in the soul of Everyman rushes to the surface with his National Continental Holiday Formulary in lightweight slacks hip pocket. Hearsay holds the rostrum though Chairman Experience ensures that Delegate Fact is not entirely unheard. So the little medicine box is stocked with all the favourite insurance policies, care being taken to ensure cover against all those terrible renowned pitfalls which lurk in foreign water, meat, fruit, vegetables, sunshine, drink, handshakes. "Don't trust the foreign doctors, and of course the cost of foreign drugs. . . . !"

How could we foresee that we would injure our knees— "Ruptured Medical Ligament," he said—on stepping out onto the arrival platform from the funicular railway; develop an allergy (horrors) to *ultra-violet light*; have a fortnight's crippling D. and V. from that gorgeous *paella* at our first meal; that junior would contract a violent phobia for non-English words; and we'll never again look at a *fondue!*

But it was a success. Enough fags and booze for a month, and Aunt Mildred, in spite of the bruises from the obsessional queue on the boat—mind you the liniment came in useful there at least—and of course we managed to get the very U melanin close to the skin surface. Cleansed in mind at least, we heavily paraphrased Auden: "It was to be ever such a thrill, In the fortnight in March or early April."

"So now you'll make sure you take a bottle of them when you go next time, won't you dear. It's ever so good."

Sex is Here to Stay

In a recent leading article the *British Medical Journal* discussed the rise of pregnancies among unmarried female students and the associated increases in the percentage of those students attending special clinics. The article, in presenting these figures, stated that this was an indication of the increasing promiscuity among students in this country, and went on to make the judgment that sexual promiscuity was both "debasing to the personalities of those who practise it" and "damaging to the interests of society". One of the explanations proposed for this increase in premarital sexual intercourse was the decrease in religious belief among most young people today.

The author of this article does not know the meaning of promiscuity, has made moral judgments which are not backed up by any form of scientific investigation and has suggested that theological morality is the only one by which society can maintain its cohesion.

According to the Shorter Oxford Dictionary, sexual promiscuity means "indiscriminate sexual activity of a casual nature". Pregnancy can result from both indiscriminate sexual activity, and from a single, responsible relationship. Marriage is not necessarily the only responsible relationship which can exist between a man and a woman. To categorise these two forms of sexual activity under the same heading, "promiscuous", is misleading and defamatory.

The censorious tone suggesting that society's interests are damaged as a result of changing sexual mores among the younger generation is probably a reflection of the essentially male influence which approves of its sons having pre-marital sexual experience, but not with its daughters. This is a morality based on male sexual jealousy, and one which is being eroded by a slowly growing male-female egalitarianism.

As the French say, there are three sexes—men, women and clergymen. Society is finding less need for an absolute morality stemming from theological dictates. There is ample reason to believe that a morality dependent upon enlightened self-interest is one that can protect the fragile bonds between men. Bertrand Russell wrote, in *Marriage and Morals*, that "Morality in sexual relations, when it is free from superstition, consists essentially of respect for the other person, and unwillingness to use that person solely as a means of personal gratification, without regard to his or her desires".

It's Begun

The latest constructions to be built on the site that will at some time contain the new buildings of Guy's, including the Tower Block, are two compost heap containers. Food for thought for the symbolists?

We offer our congratulations to Sir Charles Symonds, who has been elected an Honorary Fellow of the Royal College of Physicians of Edinburgh.

We would like to wish Mr. Gibberd, who retires on the 17th April, a very happy retirement. An appreciation will be published shortly. We welcome his successor, Mr. E. D. Morris, from Swansea.

GUY'S DIARY

APRIL			
			EXHIBITION in the Gordon Museum: CATHERIZATION.
18th	Tu.	1.00	Clinical Lecture. Professor BUTTERFIELD. "Thameshead: One Solution to General Practice."
20th	Th.	5.00	Neurosurgical Round. Mr. MURRAY FALCONER.
		1.00	Clinical Lecture. Professor TROUNCE. "The Use of Immuno-suppresive Drugs."
21st	F.	1.00	Clinical Lecture. Professor INGOLF MOLLER. "The Practical Administration of Topical Fluorides." (Dental Theatre).
22nd	S.	10.00	Clinico-Pathological Meeting in the Clinical Theatre.
24th	M.	1.00	Clinical Lecture. Dr. HILLS. "A Career in Diagnostic Radiology."
25th	Tu.	1.00	Clinical Lecture. Dr. WAYTE.
		8.00	Music Circle. TONY LEYSHON. "Shostokovitch." East Wing.
27th	Th.	1.00	Clinical Lecture. Mr. LAWRIE. "The Largest Tumours I Have Known."
28th	F.	1.00	Clinical Lecture. Dr. SCOTT. "Occupational Lung Disease."

NOTICES

Annual Blues Dinner

The Annual Blues Dinner will be held at the Trafalgar Tavern, Greenwich, on Tuesday, May 9th, 7.30 for 8.0 p.m. It is hoped that as many Blues and Half Blues, past and present, will be able to come. Cheques for £2 2s. 0d., payable to D. B. A. Silk, c/o East Wing, Guy's Hospital.

Going Down Dinner

A dinner has been arranged provisionally for those qualifying January-April, 1967. It is hoped that a good number will be present before the set finally disperses. Venue: Ye Olde Cheshire Cheese, Fleet Street, a private room on Friday, 28th April. Cost approximately £1. R.S.V.P. to E. Bowen-Jones, c/o East Wing, as soon as possible.

Golf Club's Annual Dinner

The Annual Dinner of the Golf Club will be held at the Trafalgar Tavern, Greenwich, on Monday, May 22nd. Invitations have already been sent out to known hospital golfers. Any golfer who has not received an invitation should contact the Hon. Secretary in the East Wing. Members may bring one guest. Dress will be lounge suits.

Guy's Hospital Nurses' League

Annual General Meeting and Reunion: Wednesday, 10th May, 1967, 2 p.m.—4.30 p.m.

Biennial Cocktail Party: Saturday, 21st October, 1967, 6 p.m.—8 p.m.

The Innominate Club

The next dinner of the Innominate Club will be held on Friday, 5th May, 1967, at the Bath Club 34, Brook Street, W.1. Mr. A. S. Gough, F.R.C.S., will be in the chair.

For tickets, price 47/6d., apply to G. T. Hankey, 89, Harley Street, London, W.1.

THE EFFECTS OF SMOKING *

by A. J. CAMM

"Tobacco . . . commonly abused by all men, which take it as tinkers do ale, is a plague, a mischief, a violent purger of all goods, lands, health; hellish, devilish and damned tobacco, the ruin and overthrow of body and soul."

The Anatomy of Melancholy
ROBERT BURTON

CONTENTS

1. **HISTORY**—from Columbus to the Crimea—a light-hearted introduction.

2. **THE SITUATION TODAY**—a description of existing smoking habits, including an experiment.

3. **THE CONTENTS OF TOBACCO SMOKE**—modern technology has revealed the nature and composition of tobacco smoke.

4. **THE ACUTE PHYSIOLOGICAL EFFECTS OF TOBACCO**—with an account of an experimental method used in the investigation of the effects on the cardio-vascular system.

5. **EPIDEMIOLOGICAL STUDIES OF THE CHRONIC EFFECTS OF SMOKING**—an excursion into statistical survey methods and the interpretation of these results.

6. **SOME OF THE CHRONIC EFFECTS OF SMOKING**—with especial reference to the impairment of ventilatory function.

7. **"THE FINAL ANALYSIS"**—what does the smoker risk?

8. **A SUMMARY.**

---

*This paper was awarded joint first prize, together with the article on Flourine published in our last edition, by the Guy's Hospital Physiological Society for 1966-67.

History

"In fourteen hundred and ninety-two
Columbus sailed the ocean blue"
At last he landed on a shore
That bears the name of Salvador.
At Salvador were natives bare,
With beardless chins and long black hair,
Who had a custom, past belief
Of bringing the whole world to grief:
One native, with a dextrous skill,
A maize leaf with green herbs did fill
And then, without a thought or care
Of how this cultic custom, rare
Would seize the world, and all its folk,
The foolish man began to SMOKE.

Columbus wrote: "I found a man alone in a canoe, who was going from the island of Santa Maria to Fernandina. He had some dry leaves which must be a thing much appreciated among them because they had already brought me some as a present at San Salvador."

Perhaps this was the first recorded example of a custom, now well established, of offering tobacco as a sign of welcome or of friendship.

But Columbus showed no more interest in the incident and went away. Later, in the year 1499, Amerigo Vespucci arrived, christened the New World with his own name and noticed "that the natives so often filled their own mouths so full of a green herb (tobacco) that they could hardly speak". This reminds one of those people who persist in trying to talk out of one corner of their mouth with a cigarette or pipe drooping miserably (or arrogantly) out of the other corner.

These early explorers thought of tobacco as "strictly for the natives", the uneducated and the dim. In this light it is interesting how the cigarette has become the symbol of modern Western sophistication.

The tobacco plant was brought to Europe by a physician of the time, Francisco Hernandes by name, who had been sent on a voyage to the New World by Phillip II of Spain.

In the year 1560 Jean Nicot, the French Ambassador to Portugal, sent a sample of tobacco to Catherine d'Medici, the Queen Mother of France, with a note to the effect that it possessed marvellous curative properties. It was not long, in that age of eponymous glory, before the tobacco plant became known as "Nicotiana".

1586 saw the arrival of tobacco into England. Francis Drake was the real culprit and it was he who sent some to Sir Walter Raleigh who proceeded to promote the cultivation of the plant and encourage

the custom of smoking, particularly at the English Court. Within a few years it was not uncommon to see the queen herself "a puffing at a pipe".

Raleigh did not go unrewarded—he was the first to be allowed the comfort of a smoke before his execution on Tower Hill in 1618, by order of the pen of James I, a dour Scottish monarch who had acceded to the English throne after the death of the childless Elizabeth.

In 1604 James published his most memorable work, "Counterblaste to Tobacco"; this was written because of his long lasting hatred of Raleigh and all the English Gallantry for which Raleigh stood. He was also jealous of Raleigh's substantial interest in the prosperous and rapidly developing colonial tobacco plantations. James had also been advised by some few enlightened physicians of the time that, because of the "precious stink" that is tobacco smoke, the autopsies of those that smoked revealed that their inward parts were "soiled and infected with an oily kind of soot".

> "It is a branch of the sin of drunkenness, which is the root of all sins . . . A custom loathsome to the eye, hateful to the nose, harmful to the brain, dangerous to the lungs, and in the black stinking fumes thereof nearest resembling the horrible Stygian smoke of the pit that is bottomless."

James also tried to shame people into giving up smoking by making the rumour known that tobacco was used by the South American Indians as a specific cure against venereal disease and further, he pointed out that those Gentlemen who persisted in the filthy habit of smoking ran the risk of being suspected of indulging in other filthy habits.

At the same time he threatened their virility:

> "Tobacco, that outlandish weed,
> It spends the brain and spoils the seed;
> It dulls the sprite, it dims the sight,
> It robs a woman of her right."

Meanwhile tobacco flourished. It was being snuffed and chewed and smoked in pipes all over Europe and was fast becoming the placebo of seventeenth century medicine. For example, during the Plague of England (1644—66) the boys of Eton were made to smoke a pipe of tobacco each day for the good of their health. Few schoolboys of the seventeenth century enjoyed smoking.

Tobacco had its ups and downs, fashionable at times and definitely "not with it" at other times. It was decreed against by popes and cardinals, by monarchs and by kings, but the habit prevailed against all odds and it was not long before the powers that be recognized the tremendous taxation potential of such a rapidly germinating and gripping habit. Charles I, although he hated smoking himself, was not slow to fill his coffers with revenue from this source.

Snuffing—the practice of sniffing dried and powered tobacco—was the next whim, and despite the Pope's threat to excommunicate anyone caught snuffing in church, the habit continued for many years.

It was not until after the Penninsular War (1809—14) that the cigar became popular in England although it had been fashionable for almost a decade previously on the Continent. Cigars quickly became the thing to smoke, and special small cigars "queens" were made for ladies.

With the next war, however, the smoking habits changed again—to cigarettes. These "sticks of tobacco" spread from the Continent to England and hence to America. It was the British soldiers who brought cigarettes back from their French and Turkish allies in the Crimean War.

From that day forward the popularity of the cigarette increased by leaps and bounds, until today we have this picture: —

The Situation Today

Few children smoke before the age of ten. At the age of ten, eleven to fifteen per cent of boys are smoking small numbers of cigarettes (often with parental consent and even with parental encouragement).

There is a sharp rise between the ages of eleven and twelve which corresponds to the move to the "big" school, where the child comes into contact with older boys who are already smoking. (The rise is greater in secondary modern school children than it is in grammar school children.)

A second sharp rise is seen between the ages of fifteen and sixteen which is associated with the secondary modern school leaving age. At work for the first time the young man has far more money to buy tobacco with than he had before.

The third steep gradient is between the ages of eighteen and nineteen—the grammar school leaving age. This brings the percentage of men smokers close to the adult level of seventy-five per cent.

All the rises in the light-smokers curve are reflected in the curve for more heavy smokers after some years lag.

Girls smoke less than boys; by the age of fifteen only some fifteen per cent of girls smoke at all and by the age of twenty the figure has risen to forty per cent. It is not until between the ages of twenty-five and thirty that the adult figure of fifty per cent is reached. The majority of women smoke less than five cigarettes a day, but the average is about ten per day. Men, on the other hand, smoke an average of nineteen cigarettes per day.

The difference between the smoking habits of men and women is an important fact to bear in mind when discussing the role that cigarette smoking plays in the causation, exacerbation and perpetuation of various diseases.

There is an interesting contrast between the smoking habits of British doctors and the general population. Twice as many doctors as other men are non-smokers: fifty per cent of the doctors compared with twenty-four per cent of other British men. Less than one-third (twenty-nine per cent) of the doctors smoke cigarettes alone, whereas over half (fifty-four per cent) of all British men smoke cigarettes only.

The difference between the two populations is very probably due to the doctors being aware of the harmful effects of cigarette smoking. (This view is re-inforced by a study on Lung Cancer Research workers amongst whom the incidence of cigarette smoking is virtually zero.)

It is interesting to observe the changes of the smoking habits of the medical students in my own year as they, so to speak, recapitulate the changes which the medical profession as a whole went through some years ago; or more accurately, I suppose, as they change from the smoking habits of the general population to those of doctors. I can think of many who have replaced cigarettes with cigars or polished Peterson pipes and still others who have abandoned the habit for good.

Is this in fact the case? It is not likely that those selected to study medicine at Guy's Hospital would have the same smoking habits as the general population. Is this casual observation reflected throughout the whole year?

In order to answer these questions a questionnaire was devised to ascertain the smoking habits of each person, (a) now, (b) in their first term at Guy's, and (c) before coming to Guy's. I attempted to survey the entire year and there was no intentional selection. Because of a poor attendance to pharmacology practical classes on Wednesday, 23rd November, only seventy-five members of the year were questioned, nine being women.

The results of the survey are tabulated opposite.

For the "total" results: The pre- 1965 figures correspond to those of the general population; this is probably coincidental since a group of university students in their late teens or early twenties are hardly a representative cross-section of the general population.

Several people began to smoke when coming to Guy's, perhaps because of freedom from parental influence and restraint, or for the sake of bravado or for social accoutrement. Whether the reasons were positive or negative the habit was sustained which excludes any increase in the non-smoker bracket being merely a reflection of people in this category giving up a custom which they found they neither enjoyed nor could afford. In the analysis of the figures this increase of smokers is masked by a coincidentally exactly similar number of people who had started and stopped smoking before coming to Guy's; thus, they had been recorded as smokers in a pre- 1965 period and as non-smokers in the autumn of 1965.

Figures for November 1966 show that only 39 per cent were smokers as compared with 52 per cent in the Autumn of 1965. This decrease of 13 per cent represented a change of smoking habits of ten people, all male. This 39 per cent is lower than the national figure

RESULTS OF SURVEY OF SMOKING HABITS OF 2nd M.B. STUDENTS AT GUY'S HOSPITAL ON 23rd NOVEMBER, 1966

		Male		Female		Male		Female		Male		Female		Male+Female	
		No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Pre-1965	Smokers	14	47	0	0	23	64	2	60	36	54	3	33	**39**	**52**
	Non-smokers	16	53	4	100	14	39	2	40	30	46	6	66	**36**	**48**
Autumn, 1965	Smokers	14	47	9	0	23	64	2	40	37	56	2	22	**39**	**52**
	Non-smokers	16	53	4	100	13	36	3	60	29	44	7	78	**36**	**48**
Nov. 23rd, 1966	Smokers	9	30	0	0	18	50	2	40	27	41	2	22	**29**	**39**
	Non-smokers	21	70	4	100	18	50	3	60	39	59	7	78	**46**	**61**
Pipe Smokers	Autumn, 1965	4	29	0	0	5	23	0	0	9	24	0	0	**9**	**23**
	Nov. 24th, 1966	6	40	0	0	6	25	0	0	12	45	0	0	**12**	**41**
	Changed to pipe	2	—	0	0	1	—	0	0	3	10	0	0	**3**	**10**
Autumn, 1965 to Nov. 24th, '66	Given up smoking	5				5				10					
Reasons for giving up smoking	Economy	4				5				9					
	No enjoyment	1				4				5					
	Deterioration in health	2				4				6					
	Potential dangers to health	0				2				2					

for male doctors of 50 per cent. Only one of the remaining twenty-nine smokers smokes more than the 19 per day national average.

In the Autumn of 1965 there were nine persons who smoked a pipe regularly to the exclusion of cigarettes. This represented 23 per cent of those who smoked at the time. When the present survey was conducted twelve of the smokers smoked a pipe only; these represented 41 per cent of the smokers.

In addition to the smoking histories, some of the reasons for giving up smoking were analysed: in the majority of cases the sheer cost of maintaining the habit seems to have been a powerful persuasive factor for giving up smoking. Surprisingly, a large proportion of those who had forsaken tobacco had done so mainly because they had noticed actual deterioration of their health. Contrary to my hypothesis very few had been persuaded by any threat to their health—the widely publicised threat of lung cancer, etc., did not seem to play any major part in their decision.

Criticism: ONLY 75 members of the year were questioned; may be that those who shirk pharmacology practical classes are predominantly smokers. This survey is open to all criticisms which question its validity as a true representation of the smoking habits of (a) this particular year of medical students, and (b) other years and other schools of medical students. There is little justification for extrapolating further than environmental and temporal bounds of this survey, and even within these narrow limits any conclusions are open to question.

Conclusion

My original hypothesis stated that medical students must change their smoking habits during their course from those of the general population to those of the very different medical profession. This is clearly supported, but unproven by this survey.

The basic premises, however, are transparently false: although by coincidence the percentage of smokers in the intake proved to be similar to that of the general population there is no good reason why this should be so. Nor is there any justification for believing that immediately a group of doctors qualify their smoking habits will conform to the habits of the whole profession (figures published by Doll and Hill—*vide supra et infra*).

This survey stands in isolation. Its results lack validity mainly because of inadequate supporting surveys in other student and professional bodies. However, in one direction there is a comparable survey: in 1936, it was reported in the *Guy's Hospital Gazette* of July 1st that a questionnaire had been completed in a lecture given by Doctor Boland. Of one hundred and twenty-three students who completed the questionnaire twelve were non-smokers; thus, almost 91 per cent were smokers. The author of this report assures me that this was not considered exceptional.

There has been a radical change of smoking habits since 1936. (N.B. In the general population the percentage of smokers rose until 1965.)

The Constituents of Tobacco Smoke

Tobacco is a complex mixture of gases, minute particulate matter and sub-micronic droplets of diameters from 0.3—1.0 microns.

Some of the droplets and particulate matter are deposited directly on the walls of the air sacs or are trapped in the mucus wafted towards the pharynx by the cilia of the respiratory passages. Other particulate matter is phagocytosed by the free motile cells which are in the air sacs.

Deposition of droplets of smoke upon the bronchial epithelium is dependent upon their having grown to a certain size by the adsorption of water vapour, rather than upon deep inhalation of smoke.

Previous to inhalation cigarette smoke is blue. When exhaled after one or two seconds in the respiratory passages it is white. This is because small particles of liquid or droplets scatter light more than do large droplets. The droplets must therefore grow in size in the respiratory passages by the adsorption of water vapour.

It is necessary for the droplets to remain in the respiratory passages for about two seconds to attain a size large enough to settle upon the bronchial epithelium. If the droplets are expelled quickly or are rapidly inhaled into the alveoli they cannot make contact with the epithelium. In the first case they are too small, and in the second they are deposited in the alveoli where they are speedily removed by the lymph and blood stream.

(It is suggested that it is this contact with the bronchial epithelium which is necessary to cause cancer. The habit of holding the smoke in the respiratory passages and inhaling slowly is thought to be widely practised.)

Some three hundred different constituents of tobacco smoke have been identified, many of them in infinitessimally small quantities. The two substances present in the greatest amounts are carbon monoxide and nicotine. Although carbon monoxide is found in high proportions in the mainstream smoke of a cigarette, it is seldom found in high proportions combined with haemoglobin in the blood. The percentage of carboxy-haemoglobin rarely rises above five per cent unless cigarettes are "chain-smoked" in which case it may rise to ten per cent. This is not sufficient to be of clinical significance.

A standard cigarette, weight one gramme, contains some twenty milligrams of nicotine. Of course, not all of this is absorbed:

35%	is burnt at the tip,
35%	is lost in the side stream,
8%	is thrown away in the butt,
22% i.e., 4 mgs.	enters the mouth,
3—4 mgs.	reaches the respiratory passages,
2—2.5 mgs.	is absorbed by the lungs.

Nicotine is thought to be the substance responsible for the acute symptoms produced by tobacco smoke.

Sixteen or more carcinogenic substances have been discovered in tobacco smoke, but these are present in minute quantities and it is their paucity which makes it difficult to prove conclusively that they have any carcinogenic activity in man.

At the Mayo Clinic, Ernest Wynder succeeded in producing epidermoid cancers in rodents by repeatedly applying to their skin the "tar" produced by condensing tobacco smoke. It has, so far, been impossible to produce a lung cancer in rodents by subjecting them to an atmosphere of tobacco smoke. The reason for this is thought to be that the mice breathe through their nostrils and the nostrils have a very efficient filtering system, whereas humans inhale through their mouths. Also, if mice are subjected to concentrations of tobacco smoke, adjusted in accordance with their body weight, as human beings inhale when they smoke, they immediately succumb to acute toxic effects, going into convulsions and dying within a few minutes.

In addition to these "carcinogenic substances" there are constituents which have a definite irritant effect on the mucous membrane lining the respiratory tract. These include ammonia, volatile acids, phenols and ketones. Tobacco smoke, therefore, stimulates the secretion of mucus, but it also slows the action of the cilia, thereby reducing the rate of removal of mucus. Thus, mucus accumulates.

One other constituent of tobacco smoke deserves mention—arsenic. This used to be present in tobacco because of the arsenical insecticides which were used to spray the plant. This procedure has now stopped and there is little arsenic in tobacco nowadays.

The composition of tobacco smoke is not the same as tobacco. Smoking involves a number of processes, each of which gives rise to products found in tobacco smoke:

1. Combustion produces oxides of carbon, and water.
2. Thermal decomposition occurs near the hot zone.
3. Distillation, proceeding close to the smouldering zone and giving vapours which condense in cooler regions or are carried by steam into tobacco smoke.

The three methods of smoking do not produce the same smoke. The differences are due to:

1. Nature of the tobacco: type and method of curing.
2. The temperatures produced determine the degree of oxidation, etc. Cigarettes burn at higher temperatures than pipes and cigars.
3. Filtration through filters, unsmoked tobacco and the lumen of a pipe.
4. The practice of inhalation; the alkaline smoke of pipes and cigars is more irritant to the respiratory passages than the acid smoke of cigarettes. Consequently, the smoke of pipes and cigars is not inhaled nearly as much as the smoke of cigarettes.

The Acute Physiological Effects of Smoking

(The Psychological effects although they are very important are not considered in detail in this paper.)

1. NAUSEA AND VOMITING—this is probably a direct central effect of nicotine on the chemo-receptor/trigger zone of the medulla.

Some investigators suggest that it may be a reflex by stimulation of the carotid sinus chemo-receptor mechanism. Tolerance develops and these symptoms disappear in the habitual smoker. Incidentally this is why most of the tests done on smoking use experienced smokers as subjects, thereby ensuring that the results are not obscured by these violent central effects.

2. APPETITE—It is a well-known effect of tobacco that the appetite may be depressed by a cigarette. Hunger contractions are alleviated by tobacco. (Continually replacing food with a cigarette leads to loss of weight.) In fact, non-smokers are on average, some 3—4 per cent heavier than smokers. It has been postulated that obesity is reduced in some individuals by this mechanism, and it may be that this is one of the beneficial effects of smoking.

3. AIRWAY RESISTANCE—is increased due to irritation by small sub-micronic particulate matter, resulting in local reflex spasm of the muscle in the respiratory tract. It seems that nicotine is not responsible for this effect—its concentration is too small. The resultant bronchial narrowing, which doubles the airway resistance does not cause any dyspnoea although it may be sufficient to cause slight impairment of athletic performance. Four to five fold increases in airway resistance are necessary before any dyspnoea is apparent.

4. CARDIO-VASCULAR SYSTEM—investigation pertaining to the cardio-vascular system lead to the construction of a standard "smoking test". It was devised by Grace M. Roth.

Conditions:	Constant temperature	78° F
	Humidity	40%
	Standard cigarette	

Aim: to determine the effects of smoking one cigarette on:

(a) Blood Pressure
(b) Heart Rate
(c) Vasomotor tone
(d) E.C.G.

N.B.—cutaneous vasomotor tone is assessed by measuring the skin temperature, by means of copper/constantin thermocouples, which is an index of rate of blood flow which is in turn a measure of vasomotor tone.

Method: The subject fasted for fifteen hours prior to the experiment. He laid supine in a comfortable position and thermocouples were attached to his fingers and toes. Readings of pulse frequency, blood pressure and skin temperature were taken every five minutes until constant readings were achieved; the subject had now adapted to his environment. He was now instructed to smoke a standard cigarette at a rate of one inhalation per minute. Readings were taken at every five minutes.

Results: *Blood pressure:* There was a mean rise of 20 and 14 mm. Hg. for systolic and diastolic pressure respectively.
Pulse frequency: There was a mean rise of 36 beats/min.
Skin temperature: There was a mean fall of 4.5 and 2.5° C. for finger and toe respectively.
E.C.G.: There was depression of the T wave.

The same subjects were put on an i.v. infusion of isotonic saline, samples of which contained small amounts of nicotine which was gauged to run in at the same rate that nicotine is absorbed from the lungs when smoking. The subjects who received the nicotine experienced the same cardio-vascular changes to a similar degree. Therefore, nicotine is responsible for cardio-vascular changes induced by smoking.

By how much must the nicotine content of cigarettes be reduced to abolish these circulatory changes? The i.v. infusion experiment was repeated with various quantities of nicotine.

No response was found until the amount of nicotine was raised from 0.55 mgs to 1.28mgs. If this were a true reflection of the effect of nicotine it would mean that the nicotine content of cigarettes would have to be reduced to about $(0.55/2.0)100=26\%$ of its present value. Smokers find cigarettes with this quantity of nicotine quite unsatisfying.

Of what significance are these results to the doctor?

There is a condition, known to physicians as Beurger's disease or Thrombo-angiitis obliterans, where there is inflammation of the intima of a blood vessel with clot formation. This disease is rarely seen in non-smokers (smoking "may not be a casual factor, but it is certainly the most important contributory factor."). Clinical cures can be easily effected after abandoning tobacco but are difficult if the patient persists in continuing to smoke.

But lumbar sympathectomy abolishes these peripheral vasoconstrictor effects produced by smoking, from which it may be concluded that the effects are mediated through the sympathetic system and not by humoral transmitters e.g., adrenaline.

The effects on the heart are also mediated by the sympathetic system because of stimulation of the sympathetic ganglia by nicotine causing cardio-accelerator impulses to pass to the heart.

Thus cardiac rate, output, work and oxygen consumption all rise. There is also a decrease in coronary vascular resistance in men under fifty which allows more blood to flow through the coronary arteries. But, in men over fifty, there are a large proportion whose coronary vascular tone is fixed by athero-sclerosis. Therefore coronary blood flow does not increase to meet the extra demands of the working heart for oxygen. This would seem to explain the cause of the symptoms of cardiac insufficiency such as the phenomenon known as "tobacco heart", when a pain identical to that experienced by those suffering from angina pectoris is induced. The depression and inversion of the 'T' wave of the E.C.G. recording is also typical of cardiac insufficiency.

5. DIURESIS—nicotine stimulates the supra-optic nucleus to release an anti-diuretic hormone. This effect has been demonstrated by drinking two litres of warm water to promote a diuresis and then smoking one or two cigarettes when the diuresis will stop.

The Epidemiological Study of the Chronic Effects of Smoking

To determine the immediate effects on the various body systems of smoking one or several cigarettes is a feasable experimental possibility. Furthermore, conventional agreements and standardization of techniques allows results from one group of workers to be analyzed within the framework of the results of other experimenters. The situation with respect to the investigation of the long-term effects of habitual smoking is a problem which must be faced to a great extent from an epidemiological standpoint rather than by purely experimental techniques. The difficulties which present to the experimenter are numerous, an important one being the reluctance of the subject to change his smoking habits to suit the terms of the experiment.

Epidemiological work, however, can only serve as a pointer to the possible direction of future experimentation. Like all statistical data epidemiological results are vulnerable to criticism; the results may be interpreted in several ways and it is difficult to draw any definite conclusion on the basis of epidemiological evidence alone.

Surveys to do with smoking have been conducted all over the world: in different lands, climes and races, and almost widely dissimilar general and specific populations. It is, therefore, difficult to co-ordinate this multitude of results into a composite picture portraying the chronic effects of smoking, independent of such factors as atmospheric pollution, endemic susceptibility or immunity and racial differences.

Retrospective Studies

This was the first and simplest method used to study the association between smoking and disease. A patient, suffering from the disease being studied, is asked to choose someone with whom he has made friends whilst he has been in hospital to act as a control. The investigator then looks back on the smoking habits of the two men. From results obtained in this fashion the correlation or non-correlation between smoking and the disease can be assessed.

The validity of these experiments has been criticised:

(a) Do investigators exaggerate the smoking habits of those patients they know to have the disease?

The investigator is usually non-medical and is unaware of the diagnosis prior to questioning the patient. Also in one particular survey done in a London hospital the patients investigated had been wrongly diagnosed and the results of this survey appeared to contradict the general trend. Subsequent tests, however, proved them to be

suffering from another illness and their smoking histories fell into line exactly with those of the control group.

(b) Are the control group's habits representative of those of the general population?

Probably not—but a survey conducted between people in hospital and those living around the hospital indicated a slightly higher rate of smoking in the hospitalized patient but this is of no consequence because it applies to both subject and control.

Prospective Studies

Often the results of the earlier retrospective studies have been fully confirmed by subsequent prospective studies. A random or specific sample of subjects is chosen and their smoking habits and state of health is determined, usually by a questionnaire. This same group is followed up for a number of years. All changes of smoking habits are recorded, together with changes of health and the deaths, and, where possible, post-mortem evidence of the cause of death

No mention of prospective study methods would be complete without reference to the work of a British pair, Sir Austin Bradford Hill and Dr. Richard Doll, and also the work of the Americans Hammond, Horn and Dorn.

In 1951 Doll and Hill sent a questionnaire to all the general practitioners in the United Kingdom, of whom there were 59,600, requesting details of health, smoking habits and the notification of deaths. This was repeated for a further nine years and the results from the questionnaire were then analyzed. They found statistical correlation between smoking and nine mortality rates:

1. cancer of the lung,
2. cancer of the upper respiratory tract,
3. cancer of parts of the gastrointestinal tract,
4. chronic bronchitis,
5. coronary disease without hypertension,
6. peptic ulcer,
7. cirrhosis of the liver,
8. pulmonary tuberculosis,
9. alcoholism.

The Criteria of Association

What criteria must be satisfied to deduce a definite association between smoking and a disease?

(a) *Consistency of association*—various methods of approach must reach similar conclusions.

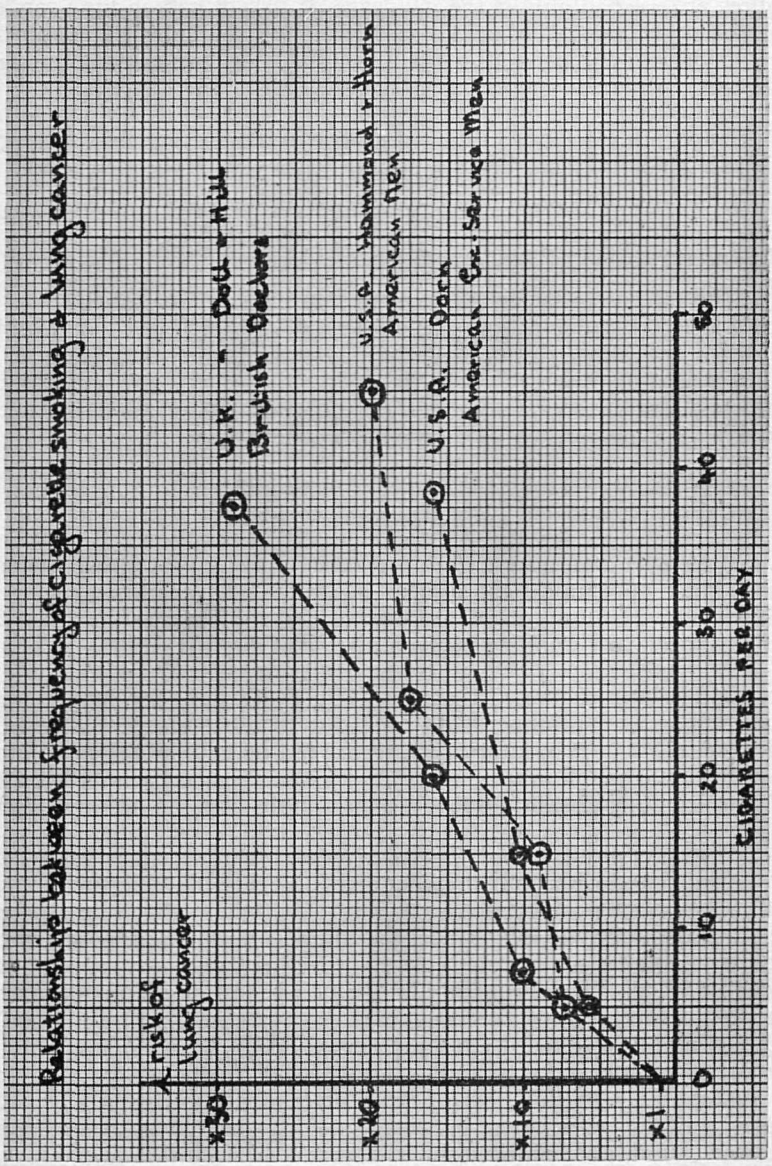
(b) *Specificity of association*—one should be able, from a knowledge of the disease, to specify or predict the probability of the victim being a smoker. Also from a knowledge of the smoking habits one should be able to predict the incidence of a disease.

(c) *Temporal association*—the postulated causal factor must preceed the disease i.e., there should be a history of smoking before any signs of the disease make their appearance.

(d) *Coherence of association*—there should be a strong coherence between the disease and smoking; the correlation should be statistically significant i.e., there should be a low probability of the association occurring by chance.

An Example

Graph I



(a) Consistency of association: all three investigations indicate a close association between the frequency of smoking and the risk of getting lung cancer.

(b) Specificity of association: individually it is possible to specify the risk of getting lung cancer from smoking. It is not possible, however, to specify the risk of getting cancer for anyone outside the specific population to which the graph refers. For instance, if Doll and Hill's figures are used to predict the incidence or risk of getting lung cancer for American men who smoke say thirty-five cigarettes per day, the prediction is twice as high as it is in reality. The two populations are different: American men only smoke one-half of each cigarette.

(c) Temporal association: this is not always present but this does not preclude smoking from being a causal factor; it simply means that it is not the only factor.

The Interpretation of Epidemiological Evidence

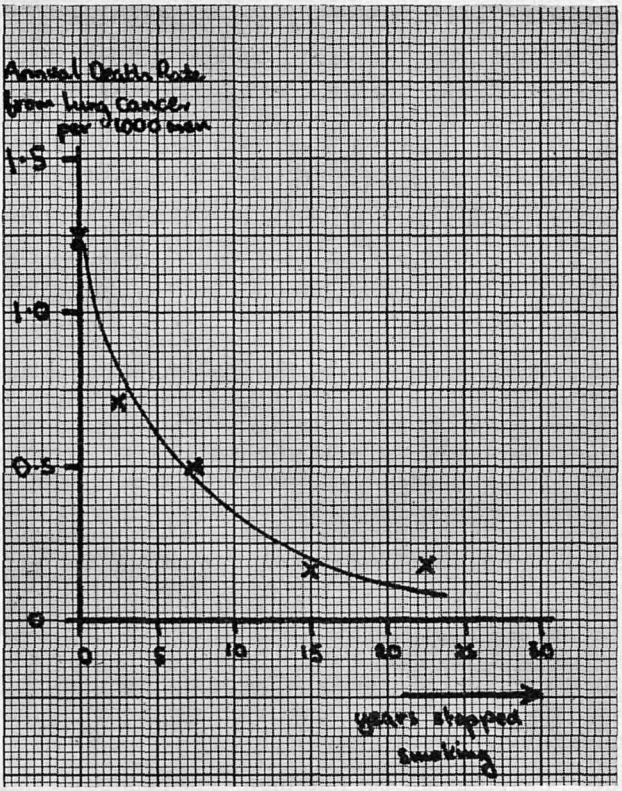
The interpretation of epidemiological evidence is difficult. It is possible to construct various hypotheses all of which fit the available evidence and although one hypothesis may seem the most likely it is not possible to prove the one and refute the others on the basis of epidemiological work alone. The observed association between smoking and lung cancer will serve as an example.

The easiest and most obvious explanation is that tobacco smoke is a causal factor, but this is not the only explanation.

It may be that years before the outward symptoms of the disease made their appearance the disease itself initiates a desire to smoke. This would seem improbable on the basis of the observed decrease of lung cancer when smoking is given up. See Graph II.

It has been suggested that the rising death rates for lung cancer may be due to the falling death rates due to tuberculosis; that many, so to speak, unfit respiratory systems are left open to attack from lung cancer. But the fall in tuberculosis is least in men and most in women whereas, in lung cancer, the rise in men is more than the rise in women.

It is also possible that there is a third factor which is independently associated with both smoking and lung cancer. One such factor which has been postulated is heredity. The factor which determines one's susceptibility to lung cancer and the factor which promotes one's desire to smoke are located closely together on one chromosome. Because of this close proximity of the two genes, or groups of genes, they tend to move together in meiosis and are said to be "linked". This is hard to reconcile with the observed fall in the incidence of lung cancer when tobacco is abandoned. This fall would not be expected if susceptibility to lung cancer were determined solely on a genetic basis and the association between smoking and lung cancer were neither causal, nor contributory in nature.



Graph II

Some of the Chronic Effects of Smoking

It is important to bear in mind that much of the evidence implicating smoking in the aetiology of disease is of an epidemiological nature. As such it must be regarded in the same light as the previous example and necessarily subjected to the same forms of criticism before assuming a causal or contributory relationship between smoking and the disease.

1. *Smoking and Lung Function*

On the fourth of May, 1966, members of tutorial group F were asked to determine their peak flow rate using the Wright peak flow meter. The subject exhales as forcibly as possible into the meter which automatically records the maximum expiratory rate of ten milleseconds duration.

This was repeated five times and the mean of the last three results was recorded.

Results:

subject	sex	age	smokes	P.F.R.
1	m	19	no	545
2	m	19	no	580
3	m	19	yes	500
4	m	18	yes	510
5	f	19	no	410
6	m	19	no	690
7	m	19	no	790

Although the subjects were mostly healthy, young men of about the same age, the mean peak flow rates of the smokers was considerably less than that of the non-smokers: 505 1./min compared with 651 1./min. Of course the variation of the results for the non-smokers and the small size of the sample makes these results meaningless on their own. But a large scale experimental study based on exactly this method was conducted in a Sydney hospital. There was a wide scatter of results, but the generally lower peak flow rate of the smoker was quite clear.

In that particular experiment the mean P.F.R. for a sixty year old, medium built, asymptomatic non-smoker was 505 1./min., whereas for a sixty year old smoker with cough and sputum the mean P.F.R. was only 322 1./min. Similar results were obtained when maximum breathing capacity was studied.

It would, therefore, appear that there is some chronic impairment of lung function as a result of habitual smoking.

(In addition there are good associations between smoking and chronic bronchitis and tuberculosis.)

2. *Smoking and the Gastro-intestinal Tract:*

The alleviation of hunger contractions and the possible consequent prevention of obesity have been mentioned in the section on the acute affects of smoking. Experiments have been conducted by means of intra-gastric balloons to demonstrate the effect of smoking on gastric motility. Batterman found these results after smoking one cigarette:

1. in one-third, no change of gastric motility;
2. in one-third, cessation of gastric motility;
3. in one-third, short rise of activity followed by cessation.

Similar results were achieved in the study of gastric secretion. However, after smoking two cigarettes in succession group 3 type subjects showed sustained increase of motility and secretion of acid. It may be this type of person in whom the chronicity of peptic ulcers is enhanced by smoking.

Doll, Jones and Pygott performed a controlled experiment on patients with peptic ulcers. Forty patients were advised to stop smoking and a further forty were allowed to continue to smoke to act as a control group. Both groups received the same treatment for four weeks after which there was a seventy-five per cent reduction in the size of the ulcer in those who had stopped smoking compared with a fifty-seven per cent mean reduction in those who continued to smoke.

There is no evidence of a causal relationship between smoking and gastric and duodenal ulceration, but it would seem that smoking aggravates and perpetuates the ulceration. There seems to be no difference between the effects produced by cigarettes, cigars or pipes.

3. *Smoking and the Central Nervous System:*

There is a condition known as "Tobacco Amblyopia". This is rare, but interesting. It is characterized by a centrocaecal scotoma particularly to red and blue. It seems to be associated with a nutritional deficiency—of Vit. B_{12}—hydroxycobalamin, which appears to render the nerve more vulnerable to tobacco. Curiously this is found more frequently in pipe and cigar smokers. A slow recovery is usual if tobacco is abandoned.

4. *Smoking and the Baby's Birth Weight:*

On average the babies of mothers who smoke during their pregnancy weigh less than the babies of non-smoking mothers. The reason is not understood, but it is suggested that nicotine may affect the blood supply to the placenta and thus affect the nutrition of the foetus.

These underweight babies are no more often malformed than other babies, are usually delivered more easily and there are fewer complications at the delivery.

"The Final Analysis"

It has been mentioned that Doll and Hill found higher mortality rates for smokers than for non-smokers in nine causes of death. But "we only die once" is a familiar cry. It is probable that we only live once and we can, to some extent, increase our chances of living longer by not smoking. The "final" analysis must convey to the smoker the risk that he is running over and above that of the non-smoker. Everyone risks death by living, by going on the roads and in many ways which are necessary for us to fulfil a useful role in society. Is smoking necessary? It undoubtedly has its pleasures and odd benefits, but are these sufficient to run the risk? What is the risk?

Percentage of men, aged 35, who expect to die before the age of 65:

Non-smokers	15%
Smokers (1—14/day)	22%
Smokers (15—24/day)	25%
Smokers (25+/day)	33%

TWICE as many heavy smokers as non-smokers die, from all causes, between the ages of thirty-five and sixty-five.

SUMMARY

There has been a steady rise in tobacco consumption since its introduction into Europe in the sixteenth century until today when almost fifty per cent of England's population are smokers. Associated with this increase in smoking habits are increases in several forms of disease. The content of tobacco smoke has been investigated and many substances, harmful to the body's systems, have been detected. The acute effects of smoking tobacco have been determined experimentally but the evidence of the chronic effects of smoking is largely of an epidemiological nature and as such is open to much criticism. However, it is highly probable that if smoking is not a direct causal factor then it is a prominent contributory factor to these diseases.

Because of these very grave drawbacks to the habit of smoking, its continuance, merely for the sake of pleasure, should be seriously considered by every individual; and each practising doctor should make the current evidence available to his patients, so that they, too, may make up their own minds in the light of knowledge and not in the abyssmal ignorance of advertising catchwords.

BIBLIOGRAPHY

1. Bott, M. (1966): "Smoking", Guy's Hospital Gazette, p. 223.
2. Cooper, P., Harrower, H., Stein, H., and Moore, G. (1958): Gastroenterology, 35, 176.
3. Davies, C. N., (1957): Dangers of cigarette smoking, Brit. Med. J., ii, 410.
4. Fletcher, C. M., (1963): The medical evidence in "Common Sense about Smoking", Penguin Books.
5. Hammond, E. C., (1962): "The Effects of Smoking", Sc. Am., 207, 1.
6. Jeger, Lena, (1963): The social implications in "Common Sense about Smoking", Penguin Books.
7. Kennaway, F. and Lindsey, A. J. (1958): Exogenous factors in the causation of lung cancer, Brit. Med. Bull., 14, 124.
8. Lowe, C. R. (1959): Effect of mothers' smoking habits on the birth weight of their children. Brit. Med. J., ii, 673.
9. Read, J. and Selby, T. (1961): Tobacco smoking and the ventilatory function of the lungs. Brit. Med. J., ii, 1104.
10. Report to the Royal College of Physicians, (1962): "Smoking and Health", London, Pitman.
11. Roth, G. M. and Schick, R. M. (1958): Effect of smoking on the cardiovascular system of man. Circulation, 17, 443.
12. Trevelyan, G. M. (1948): English Social History, Longmans, London.

BIRDS
in POETRY and PROSE

BIRDS AND BOBBLES*

Bobbles on the plane tree bob
Against the winter sky;
Pigeons on the branch hob-nob,
Cobble stones are far below.

At six a.m. the blackbirds sing,
—Bobbles on the plane tree bob—
Pigeons! when you puff a wing,
Give us patience and a dose
Of numbing empty-headedness.

We the segregated sick
Kill our cares with constant chatter,
Shiffle, shuffle to the sluice,
Drown the thoughts that cannot matter
In Bovril, soup or orange juice.

Shuffle patients, shuffle kings
And queens and knaves and hearts;
Wash your face and dry your thought,
Better pettiness than pity
When the cul-de-sac is short.

At four p.m. the starlings congregate
But never stop to concentrate
One moment more than to alight
And topple, bobble, hopple off to say goodnight.

Patient and non-fussing birds,
Can you tell us :
Why do humans squeak and scuffle
When the sunset sky
Offers dignity to muffle
Cheap self-pity and the pointless question "why"?

Bob, you bobbles on the plane tree,
Hob-nob, pigeons on the branch;
Eyes of patients carrying worry to the window
Seldom drop it
With the droppings of the pigeonry.

Birds,
Give us back our vote of confidence
In trivialities of homo sapiens,
So that when you sing tomorrow
We may go to meet
Life that's petty and expendable and sweet.

M.F.W.

*Lines written by a patient on a Hunt's House balcony.

CORNISH DISASTER

April weather, bursts of sun and huge clouds, blue skies and sea, green fields and yellow gorse, can do little to gladden the heart when eyes grow big with horror looking at the dead or struggling birds bobbing about in the rough sea, stiff with oil, and those still alive frantic in their plight.

How deceptive is the azure sparkle, the glinting lights on the sea, how fearful the seeming brown of seaweed on the rocks—it is indeed the death-dealing liquid toffee-like oil oozing in runlets over the rock surface and down to the sand, curving in thick rims along the edge of waves as the tide receeds.

On the more remote rocks beyond the reach of help, black and stiff, sea-going birds stand or flutter, awaiting death.

The first thought of the Cornish is to the birds and seals, not to the possible loss of their livelihood from fishing and tourists. On the beaches last evening there were many who, in their ordinary clothes and shoes, ran into rough seas to catch and help the victims of a ship's crew who went off course at full speed in clear daylight, putting their four million pound ship on the rocks and causing this horror on our coasts.

M.G.

REVIEW

ALMROTH WRIGHT—Founder of Modern Vaccine Therapy. Sir Zachary Cope. Publishers, Nelson. 184 pages. 42s.

When I took up Bacteriology after the war I began my career in the Wright Fleming Institute, where the dominant figure, despite his age, was Sir Almroth Wright. He was surrounded by legend and it was difficult for me to separate fact from fiction. It was therefore with great interest that I read this book by Sir Zackary Cope, then a distinguished St. Mary's surgeon, and now well known as a medical historian.

Almroth Wright had been at the centre of controversy from the start of his medical researches. Unfortunately, much of his work depended upon statistical analysis before it could be accepted by the profession; he detested statisticians and their relationship was unhappy. Hence the value of typhoid vaccine, probably his greatest achievement, was disputed up to recent times, when a good trial would have settled matters almost certainly in his favour. In the development of the opsonic index and various autogenous vaccines he moved further away from the main body of medical opinion and if his dislike of statisticians could have been controlled much of his invaluable work would have had a much greater influence.

He was a man of many interests. He devoted a major part of his thought, especially in his declining years, to a study of logic. He is also famous for his views on women as may be conveyed by the title of his book: The Unexpurgated Case Against Women Suffrage (1913).

I read this book with interest, enjoyment and profit; it tells the tale of an unusual man and an exciting period of medical research. I can recommend it both to the medical historian and the connoisseur of biography.

R. H. GORRILL.

CORRESPONDENCE

Intellectual Apartheid

SIR,—On first reading your modest Passim on the subject of the raising of overseas students' fees, I fully expected that several letters of criticism would well up from a sea of ignorant chauvinism, and this proved to be so. These emotive but philosophically malformed arguments cannot be allowed to pass unchallenged. The most basic mistake made by both correspondents is to confuse the deep sense of affront and disgust with which such a huge majority of both students and academic authorities in this country greeted the Government's introduction of what practically amounts to racial discrimination into British Universities with the monumental bad taste and onanistic glee with which a very small group of immature "students" on the other side of the river have chosen to satisfy their insatiable craving for publicity. Let us be quite clear about this—the unrealistic and boorish posturing of the lunatic fringe of the student world is wholly irrelevant to the question under discussion. However much one might deprecate their behaviour, one cannot dismiss the serious and well-considered opinion of the vast majority of those who find the implications of Mr. Crosland's proposals almost equally distatseful. I would draw your attention to the fact that at the recent A.G.M. of the British Medical Students' Association in Belfast, it was resolved that the B.M.S.A. deplores the Government decision to increase fees for foreign medical students.

To doubt, as Professor Warwick appears to, the reality and magnitude of the increase is unjustifiable, as is the apparent assumption that all foreign students are financed by their Governments. There are many thousands of privately financed students in this country, now faced with an increase in their fees of a magnitude usually limited to economists' nightmares. The effect of the increases will be especially severe on medical students with their already long and expensive course. When the student is only able to be here because of great sacrifices being made by his parents or even by his home village, what right have we who have no conception of such devotion to demand yet greater sacrifices? It has been pointed out that the increase in fees could be equivalent to about six months' worth of food for a family in a developing country.

For many years now Britain has had the privilege of having a number of overseas students in her universities, greatly to the benefit of all her students. At the moment, at a cost which is minute in comparision with our huge expenditure on wholly non-productive activities, we have in our universities the cream of the student body of a number of other countries. With all his ungraceful Jingoism about the British "taxpayer", Mr. Lux (if not hiding his lux under a bushel) would appear to be trying to drag a large red, white and blue smokescreen over the issues questioned.

It is terribly hard to imagine what mystic vision of dubious merit prompted the Government's decision, and it is becoming increasingly difficult to believe that they had any clear idea of what they were doing. Of course, one knows from experience that no matter how horribly wrong they may be, Government ministers are rarely able to admit this. It remains to be seen whether Mr. Crosland will accept the almost unanimous opinion of the real authorities on the subject; but this is unlikely, and he will probably insist on making this grubby and unworthy token gesture of mock economy.

We spend many millions of pounds annually on Aid to Developing Countries, many of whom hate us, and much of which is undeniably wasted. This proposal is carefully designed to destroy British aid and influence in its most valuable and most inexpensive form. We face the fact that Britain no longer leads the world in most spheres of activity, but must we wantonly destroy one of our greatest remaining spheres of influence by introducing this particularly obscene and viscious form of intellectual Apartheid?

Yours, etc.

MICHAEL A. SIMPSON.

East Wing,
Guy's Hospital, S.E.1.

NURSING SECTION

The views expressed in this column, as elsewhere, are solely those of their author and are not to be taken as official.

Theatre of Comfort under the Modern Lamp

Miss Florence Nightingale, throughout her life as a Nurse, radiated comfort to her patients. This was not all in tear-jerking scenes with young soldiers who were dying, but also with her intense practicability of cleaner conditions and softer palliasses. To those with whom she worked she was a tireless nurse, unsparing in her demands of others, and at times a nagging martinet—but what did it matter? To her patients she was a ministering angel.

Throughout history there have been thousands of similar but necessarily less publicised nurses. Now that nursing has become so much more technical and impersonal how do we project this essential image of comfort to our patients—both physically and spiritually?

An element of the conveyor belt system of our technical age has crept into hospitals. Patients are admitted, investigated, treated and discharged to form an ever increasing queue at Out-patient Clinics. This is all very well but where does humanity enter the scene? It is extremely easy now for nurses to fall into a routine of following instructions and attending only to the material comforts of their patients. To whom does the patient turn for comfort and unimportant pieces of advice? Not to his overworked G.P., not to the harassed O.P. Registrar and now increasingly less to the run-off-their-feet nurses.

More and more people are crumbling under the strain of the intense living and rat race to which we are now accustomed. A number of these are probably psychologically inadequate anyway, but what of those who are not? They turn up at the Out-patients department and casualty department seeking reassurance and help. Probably it is given now but it is too late. They should have the help during the original illness—practical help on coping with illness or disability and assurance on what the future is going to be like with a handicap to overcome.

What sort of atmosphere do patients like in the hospital ward. It is their right to demand the utmost that medical science can give them—and they will get this. In his day-to-day stay the patient will want an atmosphere in which he can recover. Full nursing care and reassurance when he is confined to bed, the chance to talk to other patients and to the nurses and to get to know them professionally.. An atmosphere of formality and hospital sterility is not conducive to mental well-being. A feeling that someone is interested in you and your relatives is conducive to mental quiet.

Now the big question arises as to what the nurses must tell the patient. It is not up to the nurse to tell the patient about his illness and prognosis—this is for the doctor. But the patient will immediately turn to his nurse to demand more reassurance and knowledge than that which he has been given. Doctors and nurses have to work closely with each other and collaborate on what they think the patient ought to know. Some people can take the most awful truths without batting an eyelid. Others perforce must crumble under the strain. It is up to the authorities to try and assess which patient ought to know what.

The heart breaking time comes for a nurse when she must look after a patient who is dying and who knows it. The patient may be extremely sensible and intelligent—not yet sedated by drugs. Do you shrug off the responsibility by replying to his questions with levity—"of course you are not going to die. Whatever gave you that idea." The nurse knows that this is not the truth and the patient will lose confidence in and get no comfort from the nurse. It is surely better to sit down with the patient and talk to him about this. It is not necessary to be sentimental or too practical but a medium course can be steered. Any type of help can be convened—secular or otherwise, and the patient will know that you understand his fears and anxieties and that although there is not much practical help, yet the knowledge shared is a burden halved. At this point it must be remembered that no one is going to pronounce a death sentence in the light of medical advance, but the patient can be given an outlet of hope that all is not lost. This of course does not work for all patients and there are those who are happier not knowing the truth and who gain comfort from cheerfulness and hiding the facts.

Experience will teach the modern nurse on how to deal with these difficulties but this is something that is not easy to learn—indeed, she may never learn, but will continue to try.

Sentimentality is anathema to the modern lamp but the art of comfort must be synonymous with the modern nurse. Hand in hand with technical knowledge is comfort, and the patient who recovers happily or who dies comforted has come under the influence of Today's Lamp.

STAFF CHANGES AND APPOINTMENTS

CHANGES

Sister G. Glover, from Dorcas Ward to Night Duty.

NEW APPOINTMENTS

Post Reg. Student **C. Guy, S.R.N.** (Kettering General Hospital), to York Clinic.
S/N J. Scott, S.R.N. (Guy's 1961-1964), to Luke Ward.

DEPARTURES

C/N G. M. Sibley, from Luke Ward
S/N G. Bowers, from Casualty.
S/N M. Hipkin, from Stephen Ward.
S/N M. V. Lee, from Bright Ward.
S/M G. Orme, from Victoria Ward.
S/N M. Page, from Martha Ward.
S/N J. F. Thomson, from Theatres.
S/N J. L. Ward from Samaritan Ward.
S/N S. M. Ward, from Addison Ward.

REPORT

Students' Club, 1967-68

The following students have been elected to serve on the Council for the year 1967-68:—

6 representatives of the Clinical Medical Students: F. O. Nwater, N. K. Griffin, J. G. Payne, R. A. Billings, A. M. Seal, P. J. Davenport.

4 representatives of the Clinical Dental Students: R. S. Loomes, T. Kirk, M. C. Mace, J. K. Skuse.

2 representatives of the third year medical students: Miss A. P. Hill, J. M. Morsman.

2 representatives of the third year dental students: R. Tudor-Williams, I. J. Mackenzie.

2 representatives of the second year medical students: C. G. Rowland, B. Dick.

2 representatives of the second year dental students: P. R. Hunt, B. Wright.

1 representative of the first year medical students: D. Kelleher.

1 representative of the first year dental students: T. R. L. Gould.

1 representative of the students resident in a Guy's hostel: D. B. A. Silk.

At the Annual General Meeting of the Students' Club, held on Friday, 17th March, the following officers were elected:—

Senior President: R. G. Beard, M.Chir., F.R.C.S.

Senior Secretary: S. A. R. Cooke, F.R.C.S.

Senior Treasurer: T. L. T. Lewis, F.R.C.S., F.R.C.O.G.

Student President: J. G. Payne.

Student Secretary: P. R. Hunt.

Student Treasurer: P. J. Davenport.

P. R. Hunt, *Student Secretary.*
S. A. R. Cooke, M.B., B.S., F.R.C.S.,
Senior Secretary.

SPORT

SWIMMING

Rod Jones (Guy's), described as Britain's leading sprint backstroker, did not have the supposedly comfortable win in the Men's 220 yards Backstroke that had been expected. In this third annual match between Wales and Spain, Jones, after a very slow first 110 yards (71 seconds), had lost the lead and only a desperate recovery in the last 10 yards allowed him to gain first place points for Wales by four seconds over M. Richards.

This rather disturbing performance (5 seconds slower than his best) was soon dispelled along with any doubts of him not retaining his British Team place when in the triangular swimming match between French Universities, British Colleges and British Universities Rod Jones (B.U.) established a new record for 110 yards backstroke of 65.8 seconds.

SQUASH

The 1966/67 season may be considered the most successful since Guy's were last in the Hospitals' Cup Final in 1960. It is with sad reflection that this year they were whitewashed by St. Mary's.

However, the Squash Team has managed to maintain its place in the Third Division of the Cumberland Cup. It is with thoughts of the Cumberland Cup we congratulate J. H. Newman for not losing a single match in the competition; and in playing three years for the Hospital he has only lost two Hospital Cup matches. He has also represented London University and Kent.

RUGBY FOOTBALL

Playing Easter Saturday this year Guy's entertained a weak Cambridge City. Dr. Hugh Burry made a guest appearance for Guy's and gave a reputable performance. Although the score 42—0 seems adequate, perhaps we should note that all but 10 of the points were scored in the first half.

The following Saturday Guy's beat Old Whitgiftians—a true bogey for Guy's. Unfortunately, the rugby deteriorated into a somewhat typical Old Boys' style—reflected in the score of 12—6.

For the last game of the season, against Tredegar, hopes of breaking into the Welsh Rugby Fixture List were not ripened and Guy's went down 12—6.

The Club now must change direction towards the Seven-a-Side competition. On Sunday, 16th April, they will have to defend the United Hospitals' Seven-a-Side Cup at Teddington, Middlesex.

The following week the glamorous Middlesex Seven-a-Side qualifying rounds will be abundant. On Saturday, 22nd April, Guy's, at Beckenham, will attempt to go through to Twickenham. However, Blackheath I, Old Whitgiftians I, London Scottish I and Sidcup I will also be competing at Beckenham.

RUGBY FOOTBALL

"A" XV Inter-Hospitals' Cup Final
GUY'S v. LONDON HOSPITAL
At H.O.P. Tuesday, 21st March, 1967

The sizeable and vociferous crowd at H.O.P. knew from its furious outset that this Cup Final would be played with tremendous pace and vigour. We were treated to an intensely competitive game with both sides employing fast aggressive tactics in order to force mistakes from their opponents

The sun was shining, the wind blowing, and the pitch was very hard. The ball at foot was difficult to control

Guy's played with the wind and in the early stages the fit, mobile forwards strove hard to gain the upper hand. However, the London pack exhibited an equal amount of skill and power. They were not to be intimidated.

Challacombe, a late replacement as lock-forward, dominated the first few line-outs; Hughes led his pack forcefully; Curson, Voss and Paul Williams harassed and drove on the loose ball.

During a London attack, Guy's were penalised for handling on the floor and the first three points went to London.

Guy's quickly replied with a good try. Bundred, from his right-wing position, made ground on coming into the fly-half position. Quick passing after his half break allowed Barford to dive over in the left corner. W. Davies kicked a remarkable conversion, the ball curving in majestically from outside the right-hand post.

Play swung from end to end, but the London forwards, after 25 minutes, scored a dazzling try. The initial break was made by the scrum-half on the blind-side, carried on by the loose forwards and then switched inside to the tight forwards following up in perfect formation.

Half-Time: Guy's 5; London 6.

Guy's prospects appeared bleak; against a strong wind and against a London side playing a spoiling game.

The Cup seemed to be finally beyond reach when the competent London fly-half dropped a goal even when harassed by the Guy's back-row.

London continued to put pressure on the Guy's defence, but against the run of play Davies kicked another superb goal. This time it was against the wind, the ball (magically?) curving in the opposite direction.

The score remained at 9—8 in London's favour for most of the second-half. The game continued to excite the crowd with its tension and ferocity. Injuries were numerous as the pace of the game began to tell.

Then, with only minutes to go, Guy's were awarded another penalty, this time 30 yards out in front of the posts. The imperturbable Davies put the kick over with ease, and Guy's "A" XV carried home the Cup.

This was the team that lost 10 games in succession between October and December. For the players to recover from these defeats and to maintain such a fine record after Christmas is a tribute to the overall Club spirit this season, to Dr. Hugh Burry, who has helped to coach this team as well as the First XV, and to the ever-enthusiastic captain, Brian Moore, to whom we extend our heartiest congratulations.

Guy's: W. W. Davies; D. A. G. Barford, D. G. Lewis, P. Matthews, P. E. Bundred; A. J. Scourfield, B. W. R. Moore (Capt.); A. A. Forbes, G. Voss, E. Neville, R. A. C. Hughes, S. Challacombe, L. J. Turner, P. C. Williams, D. A. Curson.

P. G. F. SWIFT

HOCKEY FESTIVAL

Friday, March 24th, to Monday, March 27th.

Guy's were as usual invited to take part in the Annual Folkestone International Festival. Gratifyingly, the whole of the regular team were available for the tournament, with the addition of Harvey, an experienced 2nd XI player.

Fortunately, the weather was a marked improvement on last year. The sun shone down for most of the first three days, making conditions ideal. Monday saw the predictable change in weather and conditions, resulting in very heavy, muddy pitches.

The first game was against Havant, on Friday afternoon. Guy's were in danger of being two players short as the last car-load to leave had travelled down in blissful ignorance of the name of our hotel. However, after a protracted tour of Folkestone, they arrived in time, and Guy's fielded eleven fit players against a Havant side, including Mark Blake, who captained Guy's six years ago. This was a fast, enjoyable game; the ball was moved about well, and Guy's produced one of their best performances of the season in drawing 2—2. Indeed, they were unlucky not to win. Against the run of play, Guy's were a goal down at the interval, Blake taking full advantage of a defensive slip. Soon after half-time, after some quick inter-passing between the inside-forwards, Cripps dribbled clear and hit the bar with a powerful shot; Godfrey was in the right place to push home the rebound. Guy's were now well on top, but unable to score another goal. A rare Havant attack produced a corner which Appleby failed to clear; from the ensuing goal-mouth scramble Havant scored an untidy goal, to make the score 2—1. Soon afterwards, Appleby thankfully atoned for this lapse by equalising with a first-time shot from a pass by J. Crafts.

Saturday morning saw most of the team taking large gulps of prophylastic fresh air on the pitch-and-putt course. In the afternoon, we played our toughest match against a strong Cliftonville team, containing several Kent "A" and Under-23 players. For the first half, they were all over Guy's and threatened to score more than the three goals that were hammered in the first 20 minutes past an overworked White, attired in a spotless new track-suit of similar colour to his features. Though Guy's played more skilful, determined hockey in the second half, they only managed to score a single goal when Godfrey scored from a rebound off the goalkeeper's pads. A final score of 1—3 was by no means a poor performance, though it must be admitted that the captain had visions of a cricket score running through his mind after 20 minutes!

Saturday night was spent mainly at our hotel of the previous year, where, we were shown considerably more hospitality than we had been accustomed to receiving as residents!

Guy's produced one of their poorest displays in losing 1—0 to Folkestone Optimists on Sunday morning. This was a drab, featureless game. One got the impression that all 22 players were lacking any enthusiasm for hockey at 10.45 on a Sunday morning.

SOCCER

U.H. Cup Final

GUY'S v. LONDON

Wednesday, 15th March, 1967
Result: lost 0—3

The teams were evenly matched. Guy's had managed to take the Cup the previous year, defeating the London 2—1 in the Final, and had now won the League Championship for the current year, the London being close runners-up. Understandably the London were bent on revenge.

As the game got under way, it became evident that both sides were primarily defensively minded. Mid-field exchanges were fairly even but chances at either end were at a premium.

Guy's were evidently lacking penetration up front and it became apparent that the 4-2-4 was bound to fail. There were too few players following play into the London's goalmouth (their goalie dropped the ball a few times).

Nevertheless, we had purused sufficient in the first half to keep our hopes alive.

The start of the second half saw Guy's attacking more convincingly—inspired by Poole—but lacking a marksman they were unable to score.

Then London took advantage of an indecisively cleared corner and crashed the ball into the net through Penman.

Stunned, Guy's allowed London to score again soon afterwards when the ball was slipped past Lovell and the London centre-forward side-footed the ball in from 10 yards.

Not many minutes after this the result was put beyond doubt when Carter being caught half-way out pushed the ball onto the bar and the rebound was duly dealt with.

..**Guy's:** M. Carter; R. Davey S. Watt-Smith, I. Nash (Capt.), R. Lovell; S. Poole, I. McClure; D. Jacobs, E. Elias, D. Lindridge, R. Leeburn.

E. ELIAS

Governors' Shield

GUY'S v. STAFF XI

At H.O.P. Monday, 20th March, 1967
Result: won 3—1

Guy's won the toss and chose to play with the wind and sun at their backs. It soon became evident that the strong wind, and a hard, dusty ground would influence the general play.

In the opening minutes the Staff XI moved the ball around very smartly, but good covering by Lovell and Davey prevented the Guy's 'keeper from being troubled. Elias, up front, was having a great game, controlling both the good and bad passes and splitting the opposition's defence with accurate distribution.

Davey, the penetrating full-back, went close to scoring on two occasions, just heading over the bar from a corner, and then scraping the post with a snap left-footed shot. But it was Elias who took the honours for the 100th Guy's goal of the season. Elias pounced on the ball, moved in the space and shot from outside the

penalty area, finding the right corner of the net.

Play still seemed to be concentrated in the Staff XI's half, but the harassing in front of the Guy's goal after breakaways by the opposition did cause some anxiety, but the Guy's defence coped well and appeared fairly solid.

Guy's scored once again in the first half through Elias.

After the interval Guy's continued to press, but many attacks were quenched by Wakefield, the staff captain and easily their best player. The Guy's attacks were fruitless until Poole picked up a ball, beat a man, and hit a low, left-footed drive into the corner of the goal, rebounding off a post.

Epps, substituting for the hospitalised Lindridge, played a fine game, co-ordinating well with McClure and Elias, but once again poor finishing spoilt the fine play.

The final result meant that Guy's reversed last year's result, and now possess a second trophy, to go with that for the U.H. League.

Guy's: M. Carter; R. Davey, S. Watt-Smith, I. Nash, W. Brander; S. Poole, R. Lovell; D. Jacobs, E. Elias, D. Epps, I. McClure.

S. WATT-SMITH

SQUASH

The season ended with the final of the Hospitals' Cup. This match proved a considerable disappointment, not for the result but for the one-sidedness of the games themselves. It was generally accepted that St. Mary's would win because of the class of the Goodwins at Nos. 1 and 2; but it was not expected that they would be able to produce such strength in the rest of their team

The story of the match is easily told: Davis and Webb were soon beaten; Thomson and White raised our hopes by starting well, but both eventually succumbed. Finally, Newman also lost in a remarkably high-class game which contained almost incredible virtuosity of shot by both players.

The Semi-final against St. Thomas's had been a much happier affair, with all Guy's players playing well and a good, but not comfortable, victory being achieved. It was a pity that the many supporters who attended the final could not have seen this much more exciting match.

Result: Hospitals' Cup

Semi-final v. St. Thomas's. Won 4—1.
Final v. St. Mary's. Lost 0—5. .
J. H. Newman lost to R. R. Goodwin, 4—9, 6—9, 9—10.
E. P. Davis lost to P. E. Goodwin, 0—9, 3—9, 6—9.
J. R. Webb lost to A. Roberts, 7—9, 5—9, 6—9.
A. A. G. Thomson lost to K. Grace, 4—9, 9—3, 1—9, 3—9.
N. M. White lost to A. Elder, 5—9, 1—9, 3—9.

E. P. DAVIS (Capt.)

BOAT CLUB

Kingston Head of the River

Saturday, 11th March, 1967

The 1st VIII competed in this 3¼-mile race for the first time. Ninety-three crews entered this increasingly popular event. Conditions this year were really difficult with a rapid flood stream and strong winds. Guy's started 54th as a new entry and were just behind Bart's I. After some precarious manoeuvering, we made a good start and were soon close behind the Bart's crew and about to overtake. However, Bart's were suddenly forced into some moored boats by another crew and Guy's were trapped for some 40 seconds behind their wreck, before we could carry on and complete the course. overtaking three more crews. We were placed 34th, although this is not a valid result due to the delay.

Reading Head of the River

Saturday, 18th March, 1967

Two crews were entered and both had a most successful afternoon's rowing. Conditions were supurb on the interesting 3¼-mile course.

The 1st VIII started 83rd, and after one of their best starts ever, soon overtook two crews at the end of the narrow Rat Island Gut. After a well-maintained effort at a fairly high rating (36 per min.) and with intelligent steering by Cox, three more crews were passed before the finish. The final position was 46th (i.e. up 37 places!) in a time of 14 mins. 16 secs. This was 1 min. 16 secs. behind the winners (the Oxford Boat Race crew). This is a very encouraging result in a race of such a high standard, as we beat many University and College crews of similar status.

Crews:

1st VIII. Bow, A. Batch; 2, P. Moulder; 3, G. Stygall; 4, N. Bax; 5, A. Hodgkison; 6, J. Miller; 7, P. Gooder; Stroke, I. Grimble; Cox, T. Kirk; Coach, M. A. Preece.

2nd VIII. Bow, P. Robinson; 2, R. Knowles; 3, J. Osborne; 4, R. Tudor-Williams; 5, I. Wilkinson (capt.); 6, A. Fenn; 7, M. Fortune; Stroke, P. Hunt; Cox, R. Stanley; Coach, P. Burton.

Tideway Head of the River

This took place after the Boat Race on March 25th. The course is from Mortlake to Putney, which is 4¼ miles. A total of 340 crews took part in this national event.

The 1st VIII started 147th. The start itself was most successful and gained valuable time. The crew then settled down to a steady row at 34 strokes/min. Once warmed up, Guy's overtook one crew after another and at the finish had passed six crews and drawn level with a seventh. The 1st VIII's time of 19 mins. 36.5 secs. gained them 82 places, putting them 65th in the overall results. This is the highest place ever attained by a Guy's crew.

The 2nd VIII, with two new members, started 209th and overtook two crews. They finished in 20 mins. 27.7 secs., which gained them 38 places, putting them 173rd—beating many other notable 2nd VIII's and some 1st VIII's.

Crews:

1st VIII: as above.

2nd VIII: Bow, P. Robinson; 2, R. Knowles; 3, J. Swain; 4, J. Skuse; 5, I. Wilkinson; 6, A. Fenn; 7, M. Fortune; Stroke, J. Osborne; Cox, R. Stanley.

With the Tideway Head, came the end of a very successful term. The achievements of Guy's 1st VIII include beating all the University of London Colleges, except for Imperial, in the four "Heads" it has entered; finally coming 65th in the only true national Head. The 1st VIII was the twelfth Junior-Senior crew. This is a very creditable performance.

The 2nd VIII has been excellent in backing up the 1st crew. Their successes include beating and maintaining last year's 1st VIII positions.

GEOFFREY STYGALL (Sec.)
MARTIN MACE (Capt.)

LADIES' HOCKEY

Results of March fixtures

Saturday, 4th March. v. London School of Economics, at Berrylands. Won 7—1.

An enjoyable game, played by an enthusiastic, well co-ordinated, attacking Guy's team.

Saturday, 11th March. London University American Tournament, at Motspur Park.

In our section of the Tournament we just *failed to reach the semi-final.*

Results of the four games played:
v. London School of Economics. Won 2—1.
v. Goldsmiths College. Drew 1—1.
v. Westfield College. Drew 0—0.
v. Royal Holloway College. Lost 0—2.

Wednesday, 15th March. v. Westfield College, at H.O.P. Lost 2—3.

This was a 7-a-side match because of the pressure of examinations. The Guy's team played a defensive game, and never looked like beating a more skilful, attacking Westfield side.

Summary of 1966—67 Season

This has been a most successful season for the Ladies' Hockey team, with many more fixtures being played and won than in previous seasons.

Fixtures, 21.
Cancellations, 9 (7 by opposition, 2 by Guy's).
Played, 12.
Won, 5.
Lost, 5.
Drawn, 2.
Goals For, 23.
Goals Against, 26.

In the **U.H. Cup** we beat St. Thomas's 3—1 in the 1st Round, but unfortunately lost 1—2 to the Royal Free in the Semi-final.

Guy's has been well represented in U.H. and University teams this season.

The team has varied immensely,over twenty students having played. The fact that all are available next season, and the majority are pre-clinicals, points to successful seasons in the future.

M E. FORTNAM

HOSPITAL INFORMATION

APPOINTMENTS VACANT

June 1st, 1967

Applications are invited for the following house appointments due to begin on June 1st, 1967, applications giving choice of post, in order of preference, to be lodged with the Superintendent, not later than **April 28th, 1967.**

House Surgeons 4
House Physicians 5
House Surgeon to the Surgical Unit .. 1
Throat and Ear House Surgeon 1
Orthopaedic House Surgeon 1
Children's House Physician 1
House Surgeon to the Thoracic Unit .. 1

The above appointments will be for six months and will be open only to pre-registration candidates applying for their first appointments and **not** to candidates seeking their second six months appointment.

Resident Obstetrician
(Post-registration) 1
Genito-Urinary House Surgeon
(Post-registration) 1
Dermatological House Physician
(Post-registration) 1
House Physician in Clinical Pathology
(S.H.O.) 1
R.M.O. in Nuffield House
(S.H.O.) 1
(To commence 1.7.67)
Resident Anaesthetists
(S.H.O.) 2
Casualty Officers
(S.H.O.) 3
Children's House Physicians at the Evelina Hospital
(Post-registration) 2
(1 to commence 1.6.67)
(1 to commence 1.8.67)
House Surgeon to Mr. Lewys Lloyd at St. Olave's
(S.H.O.) 1
Casualty Officer at St. Olave's
(S.H.O.) 1
House Physician in Medicine and Geriatrics at New Cross
(S.H.O.) 1
Orthopaedic House Surgeon at New Cross
(S.H.O.) 1

P. J. HELLIWELL,
Superintendent

PASS LISTS

ROYAL COLLEGE OF SURGEONS OF ENGLAND

Final F.F.A.

C. G. Bird
M. D. Farrar
J. J. Maher

Primary F.F.A.

J. A. Bushman

Primary F.D.S.

S. N. Bussell
C. E. Evans
R. C. Paterson
N. E. A. Renner
P. A. Sims

Primary F.R.C.S.

C. G. C. Gaches
R. J. Hart
P. W. Head

ROYAL COLLEGE OF PHYSICIANS OF EDINBURGH

M.R.C.P.E.

R. K. R. Innes

ROYAL COLLEGE OF OBSTETRICIANS AND GYNAECOLOGISTS

M.R.C.O.G.

H. O. W. Plowright

UNIVERSITY OF CAMBRIDGE

M.Chir.

R. C. L. Feneley

EXAMINING BOARD IN ENGLAND

First L.R.C.P., M.R.C.S.

I. J. Morgan

PRIZES

The Beaney Prize in Pathology

R. A. C. Hughes—Prize
M. A. Coe
A. S. Coulson
D. E. P. Shapland
} Certificates

Prize in Pharmacology

Miss A. P. Hill
Mr. T. J. Storrs
} Prize Shared

GENERAL NURSING COUNCIL

Final State Examination in Nursing

Ball, S. E.
Betts, J. E.
Bristow, S. M.
Caldwell, M. S.
Chapman, M. M. A.
Chapple, S. M.
Close, C. M.
Corfe, C. A.
Daniel, J. A.
Douglas, S. A.
Draisey, J. E. C.
Dunnett, E. B.
Edlin, A. M.
Elston, J. I.
Foreman, J. A.
Gordon, A. H.
Greany, A. E.
Hamilton, S.
Hind, E. A.
Hodges, J. J.
Hucks, J. A.
Humphreys, A. M. (née Clarke-Halifax)
Hunt, M. A. U. (née Welch)
James, K.
Lewis, C. M.
Lockett, C. M.
Macdonald, H. G.
Mackie, H. M. D.
Marshall, P.
Moody, S. J.
Morey, M. R.
Nevill, J.
Newman, D. M.
Pearson, F. M.
Potts, J. M.
Russell, A. M. E.
Spiller, A. J.
Spring, H. M.
Stott, C. A.
Teare, P. A.
Threlfall, G. H.
Turner, H.
Watson, M. E.
Weber, A. E.
Weeks, C.
Welch, J. M.
Williams, C. M.

Combined training with Moorfields Eye Hospital, E.C.1.

Edwards, C. S. M.

Combined training with Nuffield Orthopaedic Centre, Oxford.

McQueen, J. C.
Williams C. E.

PERSONAL

ASSOCIATE/ASSISTANT required from 1st May in South London. Usual clinical freedom, surgery assistance and percentage remuneration. Tel. Pol. 4340.

DENTAL ASSOCIATE/ASSISTANT with view to partnership required urgently by Guy's Dental Surgeon in Bexleyheath. Phone: 01-303 4077 or 01-303 8815 (*evenings*).

DENTAL ASSISTANT with view to partnership required in conservative three-man practice in Eastbourne. Tel. Eastbourne 30406.

LONDON, W.1. An Assistant Dental Surgeon is sought for an all-Guy's three-man practice; mainly conservative N.H.S. treatment permits sensible working hours. No Saturdays. Bachelor preferred. Telephone WELbeck 9433

CHANGES OF ADDRESS

Valerie and Peter Barrett, 14, South Cliff, Bridlington, Yorks, (Bridlington 2901).

Dr. and Mrs. John Boger, 15, Carnarvon Road, Roseville, New South Wales, Australia.

Dr. and Mrs. Simon S. Brook, "Orchard House", 53, School Lane, Fulbourn, Cambridge.

Dr. and Mrs. P. K. D. Bush, Furzetor, Eggworthy, Horrabridge, South Devon.

Peter and Ann (née Everitt) Buxton, 8, *Gosling Grove, Downley, High Wycombe, Bucks.*

Mr. P. E. Gerrard, Lau King Howe Hospital, Sibu, Sarawak.

Dr. and Mrs. E. M. Newton, 7, The Beeches, Whitepost Lane, Cobham, Kent (Cobham 247).

Harold M. Norman, L.D.S., 6, Glentrammon Close, Green-Street-Green, Orpington, Kent.

Mr. and Mrs. K. M. Pagliero, 30, The Circus, Bath. (Bath 26941). Pot of tea at any time!

Dr. W. M. E. Tweed, 63, Morey Road, Beaumaris, Melbourne, Victoria, Australia.

Miss M. Wetherell, Queen Victoria Hospital, East Grinstead, Sussex.

BIRTHS

HALL—On 19th March, 1967, to Diana (née Brunning) and the Reverend George R. Hall, a son, Jeremy David Rumney.

WALDEN—On 21st February, 1967, to Sally (née Edwards) and John Walden, at Umtali, Rhodesia, a sister for Susan.

LOEB—On 20th March, 1967, to Joan (née Sparfel), wife of Jacques A. Loeb, M.B., F.R.C.S., F.R.C.S.(C), F.A.C.S., a daughter, Victoria Joan, a sister for Stephen, Graham, Karen and Lori.

MARRIAGES

BUSH—PASKINS—On March 25th, 1967, at St. Martin-in-the-Fields, London, Dr. Peter Bush to Ann Paskins, S.R.N.

RUSSO—STAFFORD-CLARK — On April 29th, 1967, at Santa Onofrio, Giannicolo, Rome, Signore Giancarlo Russo to Priscylla, daughter of Dr. and Mrs. David Stafford-Clark.

DEATH

JOHNSON—Recently, while on holiday, Dennis Anthony Holmes Johnson, M.R.C.S., L.R.C.P., D.P.H., D.I.H., Chief M.O. Consolidated Diamond Mines of S.W. Africa.

We would like to remind our readers that all copy for inclusion in the Gazette must be received eight days before the publication date.

Personal notices one shilling per word (Minimum £1. 1s. 0d.)
Birth, Marriage, Death and Change of Address notices are without charge to subscribers.
Non-subscribers will pay £1. 1s. 0d. for all notices other than Personal.

GUY'S HOSPITAL GAZETTE

EDITORS D. S. ROBINS and C. B. BROWN
SPORTS CORRESPONDENT J. G. PAYNE
NURSING CORRESPONDENT E. A. MALPAS

FORTNIGHTLY TWO SHILLINGS VOLUME 81 NUMBER 2055

The opinions expressed in these columns are solely those of their authors and are not to be taken as the views of the Hospital as a whole.

PASSIM

Natural Selection in the Park

Destruction: inevitably a forerunner to reconstruction. The trees in the Park have proverbially burst into bloom, to gaze upon a sight that is as fresh as they are but infinitely less pleasing. Squat yellow mechanical aphids feed amorphous mechanical termites as the latter gouge their hungry way down the road alongside Hunt's House, their ugly droppings hastily borne away by subservient human ants. In the air the throbbing of compressed air pulses, accentuated now and then by the low rumbling murmur of Michelin manikins across the wooden planks of the temporary roadway—planks bearing already the disdain of the birds in the trees above. Quietly the drug-resistant pathogens wafting out of the windows above infiltrate every space as it is created below—quiet but emphatically victorious graffiti.

The ruins of a former civilization as twisting, sweeping pipes and channels buried by a man-made Herculaneum gape in the Trench. Gazing down into it the already bored eyes of would-be white, yellow, green, blue, purple and pin-striped archaeologists. Temporary railings sprout indiscreet, drought-adapted signposts bearing unlovely patterns like "Pedestrians by the footpath" in ingenuous white. Across the way the silent ivy noisily sullies the learned walls and already seeks a foothold on rejuvenating Henrietta Raphael bricks. Here, too, the machine is at work, though desperately endeavouring to lay a smoke screen on obviously clandestine activities.

Already the last-ditch stand in this Darwinian struggle is evident as the rapidly contracting grassland is bespattered by the reclining figures of students; soaking in occasional sunshine and conversation, they bravely ignore the potentially myxoedematous lunchtime clinical lecture. Their's is a sit-down protest against the apparently inexorable will of this destructive neoplasia, a protest which seems to have been ignored by the eruption of yet another metastasis now outside New Guy's House.

While the elders plan further reformatories for the diseases of Man within, the malignancy of "progress" is unchecked outside in the Park. The exhibition of cytoxics is nigh if we are to prevent it reaching the window-boxes, which fortunately still bear the relative stamp of "Made in Galapagos".

Chemical and Biological Warfare

In the last ten to fifteen years medical research has achieved tremendous successes in a variety of fields, many of which have received wide publicity in both the scientific and lay press. But one direction of development has obtained little coverage—biological and chemical warfare. This is the production and development of chemicals and biological organisms or their toxic products for their intentional employment in causing death, disability or disease in man, animals or food supplies.

The annual research expenditure on these weapons in the U.S.A. has risen from $6.5 million in 1950 to $114.5 million in 1964. Figures for the U.S.S.R. are of course not available but presumably comparable expansion has taken place, and no precise figures are known for the United Kingdom. It is generally known but not publicly expressed that research into the military potentiality of these diseases is being conducted by most major powers today.

Moreover, these weapons are likely to be used mainly against civilians. A U.S. major-general has stated that "It appears from the evidence available that this weapons system (biological warfare) would be used primarily for strategic rather than tactical purposes. Thus it is possible that the civilian and not the military population might be the main target."

In the medical profession, the debate must centre on the ethics of doctors' involvement in chemical and biological warfare, for it has been said that "no nation could develop or protect against this kind of warfare without aid from its doctors". Some would say that the doctor is presented with a conflict of obligations and duties as a doctor and as a citizen. But then, what of the experiments carried out by doctors in Nazi concentration camps. Of these, the *Journal of the American Medical Association* rightly states: "In some instances the defence has been offered that these experiments were conducted under the highest authority of the German State. That cannot be possibly considered in the slightest an extenuation of the failure of those physicians to act in accordance with the principles and traditions of their profession". Today, doctors may be instrumental in the spread of epidemics as acts of war.

Just recently, more than 5,000 scientists, including 17 Nobel Prize winners and 129 members of the U.S. National Academy of Sciences have petitioned President Johnson to halt the use of chemical weapons—riot gas and defoliants—in Vietnam. They warned against the dangerous precedent which is being set and stressed that the long-term hazards resulting from the use of these weapons far outweighed any probable short-term military advantage.

According to Rosebury, "Ethical principles are not a luxury . . . the essence of ethics—concern for the value of man—is indispensable for the survival of medicine as a profession and doubtless for the survival of mankind as a species."

REFERENCES
Effects of Biological Warfare Agents. U.S. Department of Health, Education, and Welfare, 1959.
Clarke, R. *Sci. J.*, 1966.
Rosebury, T. Medical Ethics and Biological Warfare. *Perspectives in Biology and Medicine*, 1963.
Sidel, V. W., Goldwyn, R. M. *New Engl. J. Med.*, 1966.

Residents' Play Record

A few copies are still available for order—see *Notices*.

We regret having to record the death of Dr. Clive L. E. H. Sharp, M.O.H. of Bedford. A Guy's graduate, he was a major figure in the Bedford Diabetes Survey conducted by the Department of Medicine a few years ago.

GUY'S DIARY

MAY

1st	M.	1.00	Clinical Lecture. Dr. FLEMINGER. "Amnesia."
		8.30	Inflam. Students' Bar, East Wing.
2nd	Tu.	1.00	Clinical Lecture. Mr. SCHURR. "The Surgery of Lesions of the Cauda Equina."
4th	Th.	1.00	Clinical Lecture. Mr. GLOVER.
8th	M.	1.00	Clinical Lecture. Dr. McARDLE.
9th	Tu.	1.00	Clinical Lecture. Dr. KENDALL. "Backache—Should We Manipulate."
11th	Th.	1.00	Clinical Lecture. Mr. HENRY. "Injuries of the Hip Joint."
12th	F.	1.00	Clinical Lecture. Mr. BRAIN.

How to Win Wars without actually Killing–

or

How to Kill People without actually Trying?

By

C. R. B. Joyce

Dept. of Pharmacology, London Hospital Medical College

The earliest example of non-explosive chemical warfare known dates from 400 B.C., when the Spartans made a poisonous gas, sulphur dioxide, by burning sulphur in pitch. This upset some at least of their opponents. There are also quite early examples of bacteriological warfare: the bodies of the dead were deliberately dropped into reservoirs and wells in order to render their water supplies dangerous.

The first military attempt to use the scientific methods of chemistry and pharmacology, other than in the production of explosives or simply for treatment, especially surgery, was in the First World War. Tear gases, phosgene and chlorine gas were developed then and frequently used. In the Second World War gas was scarcely, if ever, used, although all sides carried very high stocks of these earlier gases as well as of newer kinds. Many of the substances worked on in recent times are not intended for use in full-scale wars.

There are perhaps three main classes of agent for biological warfare. Physical methods include radiation, explosives and so on. Ultra-sound or high frequency sound at high intensities is also being investigated at the moment in the United States. This can be so extremely unpleasant as to be disruptive of behaviour and even physically damaging.

The chemical agents begin, relatively innocuously, with the irritants; substances which irritate mucous membranes. especially of the eyes and lungs. They include the vesicants, the substances which blister and ulcerate and eventually cause the death of mucous membranes or skin. Other substances produce pulmonary oedema and so drown the individual in the secretion of his own lungs. There are also oxidative enzyme inhibitors: if oxidation is prevented, death follows very speedily. Two very different kinds of chemical have attracted much attention recently: the psychochemicals or hallucinogenic drugs which in suitable circumstances can produce profound changes in consciousness and in the overt behaviour of the subject, and the nerve gases.

About the bacteriological agents, for the sake of comprehensiveness it may be merely mentioned that the following bacteria are serious candidates for military use: the organisms of cholera, plague, anthrax, typhoid, paratyphoid, bacillary dysentery, diphtheria and tularaemia: and also tuberculosis. The last is presumably intended for slow, chronic intervention. Rickettsiae already chosen include Q fever

(especially promising because a single organism is sufficient to infect a human being), Rocky Mountain fever and typhus; the Viruses, dengue, smallpox, various kinds of encephalitis virus, influenza and even psittacosis. Fungi (e.g., the organism of histoplasmosis) have also received attention, as well as toxins, especially botulinum and staphyloccocalenterotoxins. All those mentioned have either reached a point of development at which they could already be used, or are sufficiently well understood that it is presumably only a question of time before they could be employed. Others are so far resisting discipline.

Let us return to the chemical agents.

Three irritants have been described which differ mainly in their duration of action. For instance, CN (chloroacetophenone) has a duration of action of about two or three minutes. This is the shortest action of all. CS (O-chlorobenzalmalonitrile) has a duration of action of five to ten minutes, and DM (diphenylaminochloroarsine) of between half an hour and two hours. Apparently, these agents have been used occasionally in Vietnam. It is claimed that they are non-lethal, but there is no substance known to the pharmacologist, not even water, of which this can truly be said.

There *is* no way of winning wars without killing people, though the claim is often made that new substances can temporarily and reliably incapacitate opposition without causing loss of life. If this were true it would solve many problems with which any authority might be confronted. It would also make our topic easier to discuss. Even water can kill in appropriate conditions: that is, if the victim is over-loaded with water after being given an adequate amount of posterior pituitary gland extract. Any chemical *can* kill because the lethal dose for an individual is as much a function of the individual as of the drug. The effective and lethal doses of drugs are as a rule normally distributed. There will always be some people at the left-hand end of the distribution curve who will succumb to concentrations that are non-lethal for the majority of them. In fact, the so-called "non-lethal" gases have already killed. There have not been very many deaths but there have been some. Non-lethal chemicals are a political fantasy.

The vesicants irritate the conjunctiva and the skin, they interfere with the rhythm of the heart, and prolonged exposure to them causes peripheral shock. The blisters they cause may take weeks to heal, and they have other delayed effects. These are particularly marked upon growing and dividing tissues: blood-cell proliferation in the bone marrow may be depressed, the gastro-intestinal tract ulcerated and the function of the lymphatic and reticuloendothelial systems generally disturbed, in a way that resembles the effects of radiation. The group of vesicants includes the mustard gases of the First World War and those, like Lewisite, discovered shortly after. The new "distilled" mustards such as HN-1 and HN-3 are very much more powerful than the originals.

People who work in this area are entitled to object that, as always in science, positive benefits may arise from even the most apparently negative discoveries, as the contrary is also known to be true. The nitrogen mustards may indeed have led to remarkable developments in cancer chemotherapy, but it should not be forgotten that they have their drawbacks as well. There are as yet no antidotes, for example, to the newer irritants or mustards. The victims can only be removed from the area in which they have been poisoned, their skin or conjunctivae thoroughly washed in the hope that they have not received too great an exposure. In the gaseous form these chemicals tend to have little or no smell and therefore, since the onset of their action is delayed, the victim may already have received a considerable dose before the toxic effects make him aware of it. In liquid form they penetrate most materials easily, even plastics, and so it is difficult to provide physical protection against them.

To those substances which cause pulmonary oedema there are no antidotes either. There is a long delay in their onset of action, perhaps 24 hours, but they do at least have a characteristic odour such as the new-mown hay of phosgene. If the victim survives the pulmonary oedema, there is pulmonary necrosis to follow. Four or five of these substances are at present being tested by the armed services, but it is not known whether any of them is a candidate for serious use. If so, it is likely still to be phosgene or di-phosgene and not one of the newer substances.

The inhibitors of oxidation, of which prussic acid and other cyanic acid generating substances are the prototypes, are the quickest acting and the most lethal agents. They cause death within one to three minutes and their antidotes, which are in any case largely theoretical, are likely to be even less effective if the agent is used on a large scale.

"Nerve gases" were investigated extensively in Germany in the Second World War and in other countries thereafter. They are chemicals that combine strongly with cholinesterases, so that the transmission of information in the central nervous system and at the periphery is seriously impaired. They are colourless and odourless, and their effects at first mimic those of excessive stimulation of the parasympathetic nervous system; but they soon lead to cardiac fibrillation, convulsions and coma; and death by respiratory paralysis.

Even in the field a toxic dose of tabun (or GA as it is called in the U.S.A.) can be inhaled in as few as one or two breaths. The nerve gases are about 20 to 30 times as toxic as phosgene, but although they can kill in ten minutes, antidotes to them do exist. These depend partly upon blocking the excessive stimulation of the parasympathetics, and partly upon prying loose the toxic chemical from its combination with the enzyme. But treatment must be given quickly.

The nerve gases are certainly being produced in large quantities at the moment, in many countries. Similar substances have been

used in agriculture and in public health as well as in clinical medicine; thus, as in the case of the mustards, although the original agents were produced for military reasons, their antidotes have been used for medical ones.

The psychochemicals include lysergic acid diethylamide (LSD), dimethyltryptamine (DMT), psilocin and psilocybin. These have been used legally in psychiatry, as well as illegally: in one European city alone, many millions of pounds a year are said to be spent on their illicit purchase. Some are active in microgram quantities, and as they are odourless, colourless and virtually tastelss, it is quite easy to carry a large quantity about without detection. It follows that such a chemical could easily be smuggled by the agents of one country into the water supply of another: a bottle for only 25 aspirin tablets, if filled with LSD instead, would be more than enough to disturb the mental function of every man, woman, and child in a town of, say 25,000 people. Because individual thresholds differ widely, effects on the behaviour of a large proportion of the 25,000 people in the town would probably stop short of death: but many children would certainly die and so would some of the adults.

One or two points in conclusion. The pharmacologist is always looking for the ideal agent, in any branch of his subject: in this one, presumably, as in others. The ideal agent for biological warfare will have properties that make it difficult to detect in storage, in transit and in use. Its origin should also be difficult to determine. It should be at least difficult to identify, so that the choice of treatment, especially of antidotes (if they exist), would be complicated: just as it is much more difficult to treat a would-be suicide who is using a combination of drugs, it is harder to decide what an opponent is using to kill you, if he is doing the same. Consequently, it is likely that pure cultures of bacteria or single chemicals would seldom be employed in practice.

It should also be easier for the user of the *ideal* agent than for his opponent to defend himself against it. The cost, presumably, must also be reasonable, whatever that means (the expenditure in 1963 on chemical and biological warfare research in the U.S.A. was 150 million dollars: a four-fold increase in the budget over a period of three years). I apologise for taking many of my examples from the United States. It is greatly to the credit of the Americans that it is at least possible to discover something about the size of *their* efforts.

Finally, the ideal agent must be acceptable, in therapeutics at least. The people who take political decisions may also be concerned with ethics in choosing their ideal agents, or at least with the attitudes of those they rule. This is a matter for the individual, but some useful guidance is available. From Hugh Clegg: "the investigator in search of the truth can always claim that what he is doing is for the good of society. The doctor's ethic has always been based on his duty to care for the individual" (Clegg, 1960). Theodore Rose-

bury: "the civic responsibility for biological warfare development falls doubly on the physician as a doctor and as an interpreter of the science of disease that form its core" (Rosebury, 1963). Finally, let me summarise a point made by Kenneth Hammond (Hammond, 1965): in our political past there was general agreement about the means to be used to achieve differing social ends; in the future there is more likely to be general agreement about the ends, but disagreement about the means to achieve them.

REFERENCES

Clegg, H. (1960). *World Med J.*, **7**, 77-79. "Human Experimentation".

Hammond, K. R. (1965). *J. Soc. Issues.*, **21**, 44-66. "New directions in research on conflict resolution".

Rosebury, T. (1963). *Perspect. Biol. Med.*, **6**, 512-523. "Medical ethics and biological warfare".

Sidel, V. W., and Goddwyn, R. M. (1966). *New. Engl. J. Med.*, **274**, 21-27. "Physicians for social responsibility".

This paper was given before a conference of the Medical Association for the Prevention of War, in Oxford, July, 1966.

NOTICES

Residents' Ball

The Residents' Ball is to be held on Friday, 12th May, at the Savoy Hotel. Double tickets, costing 4½ guineas, cover the Dinner and Dance and may be obtained from M. Brummitt, J. V. Collins or myself in the East Wing.

The Ball is open to anyone connected with the Hospital and Medical School, past or present.

H. G. STURZAKER,
President of Residents

Hockey Club Dinner

The Annual Dinner will be held at The Surrey Tavern, Oval, on Monday, 15th May (7.30 p.m. for 8.0 p.m.). All Past and Present members of the Club are welcome to attend. Cost, 37/6d. including service. Cheques payable to Guy's Hospital Hockey Club.

Records of Dr. Yes

The Residents' Play Record (*Doctor Yes*) will be distributed to those who have placed an order in the next week or so. There will be a few spare copies available, and a reprint is possible if the demand is sufficient. Orders should be sent to J. S. Gregson, c/o East Wing, and 21s. should be enclosed, payable to "Guy's Residents' Fund".

Nursing Social Events

Guy's Hospital Nurses' Ball, Grosvenor House Hotel, Park Lane, London, W.1: Friday, 7th July, 1967, 8 p.m.—2 a.m.

Nurses' Prize-giving and Annual Award of Medals: Tuesday, 17th October, 1967, 3 p.m.—5 p.m. Anthony Chenevix-Trench, Esq., J.P., M.A.(Oxon.), the Headmaster of Eton College, will distribute the awards and give an address.

MUSICAL NOTES

by

G. L. DAVIES

"I have no soul for music. I am a tasteless person, but it would not cost me any regrets if the only music heard in our land were that of strict worship, nor can I think a pleasure that involves the devotion of all the time and powers of an immortal being to the acquirement of an expertness in so useless an accomplishment can be quite pure or elevating in its tendency." Though the Victorian novelist, George Eliot, may have been only 20 when she wrote the above words, it is hard to believe that she could have ever had any real love for music, though she may have later somewhat recanted from her previously rather priggish views on the subject. But then, George Eliot was an odd sort of person, not only in her own private life, but in the construction of some of her stories, *Middlemarch*, for instance. If we may digress for a moment, it is to say that this is a story largely taken up with a doctor—Dr. Lydgate—a young man who sets out to practise good medicine. As we approach the end of the book we suddenly realise that Dr. Lydgate has disappeared from the story, and we are informed, as a sort of afterthought, that he had died from diphtheria, unwept, unhonour'd and unsung apparently.

There was never a time probably when there was so much music in the air in more senses than one, nor when we could more justifiably quote that fragment of a pre-1914 "musical" which told us that "there are some kinds of music which make you sick and me sick", etc. One need not go into those kinds except to remind ourselves of those rather doleful-looking adolescents moving up and down, what time some dancing-dervish on the stage in front of them does all that one might expect a dancing-dervish to do did one ever see one.

To some, musically speaking, the human voice provides all that they require, and to listen, say, to the sensuous beauty of some of the notes of a Victoria de los Angeles is to be carried away with the same conviction. There are others, however, of one of whom, a popular idol, a music critic said the other day that her voice went through his frontal lobes like a very cold ice cream.

To my mind nothing can excel the grandeur of a large orchestra. When it is playing and says "fortissimo" I like it so, whatever the medium may be which is reproducing the particular work; all the

undertones become submerged if one keeps up a continuous pianissimo. "Let it roar," as Mr. Churchill said in one of his inspired moments though not, of course, about music. To illustrate this love of crescendo on my part (only, of course, when it is indicated) there come to mind readily Respighi's "Pines of Rome"; Wagner's "Entry of the Gods into Valhalla" in his *Götterdämmerung*; a similar sort of cavalcade, if one may call it such, in Grieg's "Ride of the Valkyries" in his *Peer Gynt Suite*; perhaps in Ravel's *Bolero,* where one waits patiently for the climax of sound, and to a lesser extent in the same composer's "La Valse". But one could go on endlessly enumerating one's moments of ecstatic sound and thanking Heaven for the joys of good music and for the geniuses by whom it has been composed.

The modern orchestra has only reached its present state of perfection with countless trials and errors, and with many permutations and combinations of instruments, in an attempt to reach a perfect balance. It is no exaggeration to say that it has taken some thousands of years to reach the present apotheosis, from the twanging of some dried ligament and the banging of a taut skin by a primitive savage to the expensive and complicated instruments of today. Nebuchadnezzar, we remember, ordered his people to come and worship the golden image which he had set up whenever they heard the sound of the "cornet, flute, harp, sackbut, psaltery, dulcimer and all kinds of music" though he has probably been given more musical credit than he was really entitled to; and Ur of the Chaldees is remembered, musically, for the graceful shapes with which his musical instruments were designed. Of Arabic origin was the first stringed instrument to be sounded by a bow, the *rebab,* mentioned by Chaucer and again as the "jocund rebeck" by Milton. From the rebeck grew the "viol" with its six strings, a popular instrument in Tudor and Stuart times until the year 1685. At this point Stradivarius and the Guarnerus family at Cremona come on the scene and the viol is transformed into the present 4-stringed violin, viola and 'cello. This was an epoch-making transformation, for in any full orchestra the strings comprise two-thirds of the total number of instruments and the cohesion of the string parts is the conductor's chief care. Incidentally, the year 1685 is notable for the birth of Bach, Handel and Scarlatti.

The modern orchestra consists of four parts as all concert-goers will, of course, know. From before backwards (speaking anatomically) they are strings, brass, woodwind and percussion. Such orchestras have given the world the greatest masterpieces of music; but, as hinted above, securing the proper balance of the various instruments has been a problem of the greatest difficulty and the subject of much experimentation. We are indebted to the Romans for the origins of our woodwind and brass instruments, their tibia, cornu and tuba for the former and their buccina for the latter, these being, no doubt, used in their military formations.

We are also much beholden to the troubadours of the Middle Ages for the preservation of instrumental music, the cultivation of which was discouraged or destroyed by the Church. Coming down to Tudor times we note the first great occasion for the use in concerted instrumental music of percussion instruments, viz., the timpani or kettle drums, by Purcell, though percussion as an accompaniment to song and dance goes back to primitive times. Bach and Handel used the timpani often and Haydn and Mozart more often still. Trumpets and drums then start being popular to produce a sonorous effect. The difficulty of getting a balance with the woodwind was overcome by the invention of the clarinet and the complicated business of trumpet or horn-blowing was solved in 1850 by the invention of valves to these instruments which made them much more "flexible". Now the woodwind consists usually of two each of flutes, oboes, clarinets and bassoons.

Mozart is regarded as the parent of modern orchestration and, in the varied experimentation with brass he is notable for his use of the trombone, producing a great effect with three of these in *Don Giovanni.* Inspired by Mozart, Beethoven was the first to use three trombones in a Symphony (the 5th) and three horns in his *Eroica* Symphony (the 3rd). Schubert, however, is the supreme example of the successful use of trombones, principally in his *Unfinished* Symphony (No. 8 in B minor) and also in his C major Symphony (No. 9). Schumann used them in each of his four Symphonies. The increasing use of brass, of course, did much to enhance the sheer volume of sound which could be produced by an orchestra, so much so that Richard Strauss's advice to conductors was, "Never look at the brass, it only encourages them". At the turn of the century the ever-increasing size of the orchestra began to present some problems. Berlioz aspired to huge orchestras and so did Wagner, but Wagner's were better balanced than those of Berlioz and, in fact, Wagner's orchestration has never been equalled. Compared with Mozart's 35 strings, he had 64, which only goes to show the richness of sound desired by Wagner (e.g. "The Ring of the Nibelungs"). In his *Benevenuto Cellini,* Berlioz makes great play with his brass and percussion instruments; one must not forget that these can comprise cymbals, glockenspiel, celeste, and xylophone in addition to the usual timpani. With Richard Strauss (1864-1949) the orchestra exceeded in size even that of Wagner and this is seen particularly in his *Ein Heldenleben* and *Till Eulenspiegel.* Later on Stravinski with his *Sacre du Printemps* produced a perfect pandemonium of sound. Whilst Haydn is regarded as the "Father of Symphony" one somehow regards Beethoven as the master of that *genre,* and everyone musically inclined will know his *Pastoral* and *Eroica* symphonies at least. With Beethoven classical music came to an end and was followed by the Romantics (Schumann, Liszt, Chopin, Berlioz, Wagner).

Before we go, let us not forget Brahms (1833-97) and his four symphonies, his First Symphony being once described as "one of the

greatest masterpieces of intellectual thought and beauty ever conceived in symphony form". He was the master of counterpoint and the last of the great classicists. He chose the older form of musical expression and steered clear of the Romantics. Brahms, on the other hand, as distinct from his predecessors, often changed the key (chromatic music). The latter were content to pitch three out of four movements in the same key (diatonic music).

But of the writing about music, as of modern Medicine, there is no end. One can only touch the fringe of it, and involuntarily, if irrelevantly, there comes into my mind some words from Milton's *Il Penseroso* about "calling up him that left half-told the story of Cambuscan bold". And whoever Cambuscan may have been we must share with him the odium not merely of only telling half a story, but only telling a mere fraction of it, for we have not even mentioned Mendelssohn, Tchaikovsky, Dvorak, Sibelius and Elgar, without some of whose melodies one's musical library would be sadly incomplete.

CORRESPONDENCE

A Brighter Light?

SIR,—Mr. Simpson (*Gazette*, April 15th) has, alas, rather destroyed his argument by resorting to a personal attack. Unbowed, I would say to Mr. Simpson, that I might be hiding my Lux under a bushel, but am spreading a little light on a vexing problem.

After stating that the B.M.S.A. passed a recent motion deploring Mr. Crosland's action and that most students and academic authorities also deplore the move, your correspondent then puts the taxpayer in italics. Again I stress that the taxpayer who foots the bill for students to express their abhorrence of Governmental action has some say. Strange that when these intellectual nitwits staged a sit-down at L.S.E., and paraded in long-haired array through many towns, the taxpayer was not moved to join their protest.

It is also pertinent that the new rebel student body who have been the most vociferous in protest can claim some active Communists among their leaders and no doubt Party funds have helped their action; it is strange that Communism and left-wing Socialism flourishes amongst students and their teachers; probably a case of their being shielded from the realities of life. For that is what I am, a realist, not the idealist of Mr. Simpson and his kind.

If Zambia can imprison British subjects without a charge laid against them, if Spain can subject Gibraltar to hardships, and if these new countries in Africa and elsewhere are so determined that British rule end, then why should the British taxpayer have to pay continually for the doubtful privilege of seeing his country ridiculed and humiliated throughout the world?

No one forced self-government on Ghana, Sierra Leone, Zambia and the like; they wanted it, and now expect the "hated" British to continually subsidise them. Face facts, Mr. Simpson, the "Great" in Great Britain is a little worn these days.

The editorial in the *Daily Mirror* of April 17th stated the position, and God knows they are not exactly Tory supporting: *"Government spending overseas and at home is the core of the problem. The folly of living beyond our means continues with insane abandon."*

We no longer have the ever-open purse, and as University and college building has been slowed drastically because of lack of funds, it is right that not only should the subsidy to overseas students be pared, but even the number of places allocated to them be scrutinised, in view of the thousands of British would-be students who are denied a place.

Yours, etc.,

L. B. LUX

Strathyre,
Warwick Road,
Hale, Cheshire.

First and Last

SIR,—*Passim* in the last issue entitled "Sex is here to stay" can hardly be described as based on evidence (as the writer suggests such articles should be). Take for example the following: "Pregnancy can result from both indiscriminate sexual activity and from a single responsible relationship. Marriage is not necessarily the only responsible relationship which can exist between a man and a woman. To categorise these two forms of sexual activity under the same heading "promiscuous is misleading and defamatory." If it is indeed defamatory it implies that the majority of these relationships are in fact responsible. Presumably this means responsible in the purely moral sense, as for example in the passage quoted from Bertrand Russell and not in the sense of social responsibility which in our society precludes extramarital sexual intercourse in its moral code.

The couple concerned could be classed as morally responsible in two circumstances:

(1) If they were forming a relationship equivalent to marriage (in that it is formed with the purpose of creating a lifelong exclusive partnership) but still did not believe in the validity of the ceremony.

(2) If they were convinced that premarital intercourse was a healthy and morally acceptable preliminary to marriage.

The first case cannot be a seriously proposed basis for suggesting that the *majority* of premarital sexual activity was responsible.

The second is, I think, untenable as responsible on two counts:

(a) The old adage:-

Every man hopes he is the first;
Every girl hopes she is the last;

still applies as anyone working with young people and many surveys have confirmed. A boy may be sexually experienced but will still wish to *marry* a virgin.

(b) Although the couple may be convinced of their moral right they take no account of the social predicament of a child born out of wedlock.

I can therefore see no basis, and *Passim* has certainly supplied no argument, whereby these relationships can be classed as responsible.

Finally an unbiased observer must agree with the author of the original B.M.J. article that the increase in extramarital sexual activity *is* related to the decline in religious belief. This may of course be a good thing, freeing man from domination by the church and its doctrine.

The responsibility for deciding our code of behaviour now rests with us as members of our society. I personally hold that the best available guide to not only Christian but socially responsible behaviour is, in fact the Bible.

Yours etc.,

JOHN H. TRIPP

East Wing,
Guy's, S.E.1.

[EDS:—*The Devil can quote Scripture.*]

Sex is but a Link in a Chain

SIR,—I was interested to read the editorial "Sex is here to stay". The writer is at pains to point out that pregnancy can result from promiscuity ("indiscriminate sexual activity of a casual nature") and from "a single responsible relationship" between unmarried partners. But can any temporary relationship—whether it lasts for a week or a year—resulting in a pregnancy outside marriage, be described as truly responsible? Any relationship in which the partners are not wholly committed must lead to an insecure background, and one which is not well suited to the bringing up of children.

Bertrand Russell was right. "Morality in sexual relationships . . . consists essentially of respect for the other person, and unwillingness to use that person solely as a means of personal gratification, without regard to his or her desires." In marriage, intercourse strengthens a relationship already established. By fornication a relationship which is only tentative is obscured and confused. Marriage should lift a man and woman out of their natural egotism and lead them to share their lives with each other. It should be the very highest love which binds them, and it must be of the kind where each looks for the highest good of the other; mere passion or inclination will not do this. It is in such a bond that true character develops and personality grows. The result is that both gain much and are thereby equipped for the nature and training of a new generation.

The editorial's writer does not seem convinced that society's interests are damaged as a result of sexual promiscuity. However J. D. Unwin in his monumental study "Sex and Culture" examined all the world's principal civilizations and eighty uncivilized societies and then wrote, "Any human society is free to choose either to display great energy or to enjoy sexual freedom; the evidence is that it cannot do both for more than one generation". Prof. P. Sorokin, the Harvard Sociologist, in his book "The American Sex Revolution" describes the Russian attitude of the twenties. "The Revolution leaders deliberately attempted to destroy marriage and the family. The legal distinction between marriage and casual sexual intercourse was abolished. Bigamy and polygamy were permissible under the new provisions. Abortion was facilitated in state institutions. Premarital relationships were praised and extramarital relationships were considered normal . . . Within a few years millions of lives, especially of young girls were wrecked. The hatreds and conflicts among polygamous and polyandrous mates rapidly mounted, and so did psychoneuroses. Work in the nationalized factories slackened . . .The government was forced to reverse its policy".

If *Passim* is so doubtful of these effects of promiscuity, perhaps it would furnish us with the references to scientific investigations which show clearly that sexual promiscuity is *not* "damaging to the interests of society" and "debasing to the personalities who practise it".

Yours etc.,

J. ALLISTER VALE.

East Wing,
Guy's Hospital,
S.E.1.

Love is more than . . .

SIR,—In your provocative Passim article entitled "Sex is here to stay", you suggest that a single couple who indulge in sexual intercourse without promiscuity ("indiscriminate sexual activity of a casual nature") may be said to be having a responsible relationship. However, the article ends with a quotation from Bertrand Russell which contradicts this argument; "Morality in sexual relations . . . consists essentially of respect for the other person, and unwillingness to use that person solely as a means of personal gratification . . . "

How can one say that a couple such as has been mentioned, show respect for each other? If they intend their relationship to be a permanent one, why do they not get married rather than subjecting each other to the anxiety of an insecure relationship made worse by the possibility of bringing a child into such an unstable milieu? (No method of contraception is 100 per cent effective). Alternatively, if they do not intend to stay together, their intercourse is nothing but a means of

personal gratification done without consideration of the psychological trauma which will result (to the girl especially) when they part. In either case the motive is not respect or love, but disguised selfishness.

Even if one has no religious convictions there would seem to be a good case for retaining a moral code which has, incidentally, stood the test of many centuries.

Yours etc.,

MALCOLM J. H. HILLIER.

St. Christopher's House,
208, Long Lane,
S.E.1.

More Words

SIR,—Three more words for Stewart Cameron to add to his collection of meanings corrupted in medical English: First, *Anginal*: Cardiac pain? Or just hedging? Then, *Benign*: applied to hypertension or a tumour this term can only imply that these conditions provide a natural beneficence, conferring advantage beyond the normal. And lastly, *Functional*: to mean innocent, as though all murmurs were not functional. There are no murmurs from the dead.

Yours, etc.,

I. McD. G. STEWART

125, St. Annes Road East,
St. Annes-on-Sea.

British Empire Cancer Campaign

SIR,—Once again the British Empire Cancer Campaign Flag Day Depot will be at Guy's Hospital, on Tuesday, 23rd May.

If any members of Guy's or their friends would like to sell flags, it would be very much appreciated. The Depot is at Matron's Office from 7.00 a.m. to 2.30 p.m., where the tins and flags can be collected. The area is from London Bridge Station and on both sides of the Borough High Street up to the "George".

Yours, etc.,

ELIZABETH CLARKSON,
Treasurer of the Ladies' Committee
of the British Empire Cancer Campaign.

GENTLY DOES IT

by

JOAN SAWYER

Nurses often ask why some patients who create considerable disturbance in the general wards, behave very differently in the York Clinic. I wonder if these nurses ever ask if they themselves behave with similar disparity, and if so, why? Truth to tell, we nurses are creatures of conditioning and we behave in different situations according to that conditioning and our patients respond to us similarly.

So, in the general wards, when an emergency arises to disturb the even tenor, we jump to it. "Screen the bed, close the windows, turn back the counterpane, and explain to the patient what you are going to do." In fact, change the whole environment of the patient as quickly as you can, and however politely you do it, assume an authoritarian attitude. This works quite well when you are dealing with patients who willingly submit to your authority as most people in acute physical distress will. (A nurse I know once attended a Prime Minister in his hour of sickness. "Tell me," he said, "just what you want. I will do exactly as you say." She has always regretted since that she did not get income tax abolished for ever.)

When it comes to dealing with the patient in acute mental distress, this approach is worse than useless. The patient is out of touch with the real situation. He may not know who you are, where he is, why he is here, and is certainly unaware that he is in a place of friendliness and help. He is a man in a nightmare peopled by terrifying creatures of his past or his fantasy, cut off from all that is friendly and familiar and reassuring to him. As his anxiety rises, everybody and everything grows more threatening, until he must rush out of the ward, or leap out of the window, or fight his way past people—the sort of thing that ordinary people may do if trapped in a burning house. Even if a patient seems rational enough, if very depressed he has not even himself for a friend. As tension increases, the self-destructive impulse overwhelms him, and he becomes his own executioner.

The psychiatric nurse therefore conditions herself to a different approach—the accepting one, in which she relates to the patients as they are and keeps in communication with them as persons. The general ward Sister who finds time for the daily individual chat with each person about himself as well as his illness, is less likely to have disturbances in her ward than the one who only spares time to say and listen to what seems essential to the treatment.

When confronted with disturbing behaviour, the psychiatric nurse will take the opposite approach to the brisk jump-to-it one. "Change nothing in the environment unless it is dangerous. Approach the patient, facing him all the time, but not so close that you threaten him, and try to find out what he is trying to do." She can then see his activity in context, against the background of the fantasy world he is now inhabiting. She will then build a bridge of reassuring communication to him from her world of reality to his terrifying one.

Thus, if a patient disturbs the peace by say, knocking the medicine glass out of your hand and swearing at you, respond to this not with moral indignation nor with fear, but with a detached professional judgment that you have a disturbed patient on your hands, and soon if you are not careful, you will have a whole disturbed ward on your hands. So dispatch someone to go quietly round the other patients assuring them that the patient will harm no one—that he is very upset and unwell, but that the nurses understand the situation and can deal with it.

Proper medication will be needed, tranquillising drugs and possibly parentrovite.

Meanwhile, get into communication with the patient. Stand just out of arms reach, quietly removing anything from the locker that could become a missile. Anchor any vulnerable apparatus such as a blood bottle or a thoracotomy tube.

If your hands are not on essential work, hold them loosely in front of you, palms upward—relax your shoulders and face. Never turn your back on him—you take away the reassurance of a human face. Patients read non-verbal communications of facial expression, posture and gesture very well. Tell the patient you know how frightened he is, but that he will get better; then try to get his memory to bear on the situation. Recall to him by short questions asked slowly, clearly, in a voice of moderate pitch, who you are, where he is, why he is here, what time it is. Give time after each question for the confused brain to sort out the answer. Though you receive no coherent reply you will see him relax minimally. Talk gently and soothingly, helping him to remember; your own assurance will come with practice. If he has gone away from his bed, and the tranquillizer is now ready for injection, offer him your hand and invite him to return to his bed. If he is too disturbed to co-operate fully it is best to enlist two or three helpers so that two can take an arm each, one can impel the patient from behind, and talking to him

gently all the while as if he were co-operating, persuade him physically back to bed. It is easier to walk the patient backwards if he is much taller than the nurses. The third helper is useful to open doors, prepare the bed, draw the curtains, etc., or to add strength to the nurse in the middle. To restrain the patient while the injection is given, turn him on his side, talking again to him as if he were co-operating, place the limbs slightly across their partners so that the uppermost limb anchors the lower one when a nurse leans with her open palms over wrists and elbow, and ankle and knee, putting her weight on them at the moment of injection. The third nurse looks into the patient's face and synchronises what she says with what is being done. The fourth nurse gives the injection deftly and quickly, the patient being released immediately the syringe is withdrawn. Two nurses remain to settle him comfortably, and one stays nearby until he is himself again. The drug may need to be repeated periodically for at least 48 hours, and this will keep the patient tranquil until further advice is obtained.

It is as well to note here that the Sisters in the York Clinic are not averse to asking advice about surgical or medical nursing from their colleagues who are at present working in such wards, and they would gladly return the compliment by having their advice sought in regard to psychiatric patients.

Of course, in the interests of economy, one could use the psychiatric approach just as well in the general ward. General patients respond to it as well as psychiatric ones and children. When people are accepted as individuals in their own right of their own age, stage and condition, good relationships develop and a therapeutic atmosphere is created. In this atmosphere sick people get well, students learn well and children grow up well. Boards of Governors should love it because it costs nothing in hard cash.

Every Guy's trained nurse since 1961 has been taught the psychiatric approach in the classroom, and when she is in the York Clinic she usually practises it, because she receives the right cue from the trained staff there. In the general ward she is so conditioned to the authoritarian jump-to-it approach that she cues herself to that, and as it were goes in feet first, when what she really needs to say is "This is different. I must play it cool. Gently does it."

NURSING SECTION

The views expressed in this column, as elsewhere, are solely those of their author and are not to be taken as official.

St. Olaves' Hospital. Nurses' Prizegiving.

The sun shone on Friday, April 14th, on the occasion of the Nurses' Prize-giving at St. Olaves' Hospital. Outside, the grounds looked most attractive, and within there were masses of beautiful spring flowers.

It was a very friendly, informal occasion with a large number of parents and friends assembled to see the nurses receiving their prizes and certificates from Miss Barbara Kelly.

Richard Hayward, Esq., C.B.E., Chairman St. Olaves' Committee, gave the Opening Address and welcomed the visitors.

The Superintendent of Nursing, Mr. Roy Macrae, reported on the achievements of the past year and outlined the plans for the future. He emphasised the special contribution which St. Olaves' could make within the Guy's group.

In her own inimitable way, Miss Ann Miller, Principal tutor, gave her report. She had been encouraged by the increased recruitment, and hopes to commence the new syllabus of training this year.

Prizes and certificates were then presented by Miss Kelly.

In a short address she spoke particularly to the nurses and their parents. She expected a nurse to be efficient, but with a sense of humour, and thoughtful in her relationship with people.

A vote of thanks was proposed by Dr. A. J. Oldham, Consultant Psychiatrist. The afternoon ended with a delicious tea.

T. SWINDELLS

BOARD OF GOVERNORS' PRIZE FOR HOSPITAL EXAMINATION
1st, Wendy Ann Thorogood
2nd, Mary Wickham
3rd, Mary Teresa Brennan

BOARD OF GOVERNORS' PRIZE FOR NURSING
1st, Wendy Ann Thorogood
2nd, Ann Josephine Tedford
3rd, Mary Teresa Brennan

MR. R. A. V. LEWYS LLOYD'S PRIZE FOR SURGERY
1st, Wendy Ann Thorogood
2nd, Janet Margaret Duffill

DR. J. H. MASON'S PRIZE FOR MEDICINE
1st, Gwendoline Susan Davis
2nd, Gloira Ann O'Neill
Bridget Teresa Ryan

DR. J. FULLERTON'S PRIZE FOR BACTERIOLOGY
Sylvia May Anderson

MR. E. W. BROCKIS' PRIZE FOR PHARMACOLOGY
Georgiana Euphemia Aspinal
Mary Elaine Morgan

THE JAMES ALFRED BICKEL PRIZE
Wendy Patricia Ansell

SUPERINTENDENT OF NURSING'S PRIZE FOR PROGRESS
3rd year, Barbara Lucy Bygraves
2nd year, Catherine Frances Anne Gaynor
1st year, Catharine Teresa McMahon

PRINCIPAL TUTOR'S PRIZE
Anne Angela Macken
Norma Patricia Chang
Susan Ann Whitman
Jeanne Elizabeth Cronk

Congratulations

We congratulate Miss Jennifer M. Hunt (Guy's, March 1962-1965) now completing an Hons. B.A. in History at Bristol University, on being selected to pursue a two-year research project under the aegis of the R.C.N. and the Ministry of Health. She will start work in October 1967, at the R.C.N., London, initially spending two terms learning something of research methodology. The project in nursing care, is expected to last six years in all, involving three groups of six nurses.

STAFF CHANGES AND APPOINTMENTS

DEPARTURES

Sister B. Higginson, from being in Charge of Orientation.

S/N E. C. Charron, from Nuffield C Floor.

S/N E. Dobb, from Diplock Ward.

S/M D. C. Gordon, from Victoria Ward.

S/N V. Kirkwood, from Outpatients Department.

S/N A. Oxley, from Outpatients Department.

REVIEWS

SYMPOSIUM ON CANDIDA INFECTIONS.

Edited by H. I. Winner and R. Hurley.

E. & S. Livingstone Ltd. *Price* 35s.

The first impression conveyed by the title suggests that one could learn a lot on reading this book. However, the Editors make it clear that it is not intended to give a complete or systematic account of Candida infections. This is true and consequently it was disappointing to read. This may be because each contribution was written primarily for oral communication and has not been changed sufficiently to make palatable reading. Perhaps the main fault with this book is that it is too long. If it had been confined to about 100 pages it would have been much more crisp and digestible. However, as it stands it is somewhat like spaghetti—long drawn out and very little meat.

J. T. SMITH

AN INTRODUCTION TO SOCIAL MEDICINE.

by Thomas McKeown and C. R. Lowe. Blackwell. 327 pages. *Price* 50*s*.

This is an excellent book which gives a fair account of the problems of medicine in society and the methods used to control these problems. Nearly half the text is devoted to the British health and welfare services with a short reference to international problems and the work of the World Health Organisation.

The authors cover all the material required by undergraduates in the field of Social Medicine and the book can be recommended for them. It will also prove useful as preliminary reading for those who are about to specialise in Social Medicine or who may be preparing to start the D.P.H. course. It differs from many books in this subject in that it is very readable, but it should not be assumed from this that concentration is unnecessary. This is partly due to the fact that visual aids are relatively limited in number (24 figures and 33 tables) and that some of them are rather far away from the relevant text. It is a book for those who want an intelligent grasp of the subject rather than those who require a few snippets of information.

J. A. D. ANDERSON

CLINICAL CARDIOLOGY.

by Velva Schrire (Cape-Town). 2nd Edition. 1966. Staple Press. *Price* 70*s*.

This is a specialised book on the clinical aspects of heart disease, which is intermediate in scope and size between the standard medical texts and larger reference books, e.g. "Paul Wood".

The layout is in the standard form of these books—symptoms; signs; investigations, etc., are dealt with in order by chapters.

A major attraction the book has for me is that a pathophysiological approach is used, wherever possible, in simple informal terms: some sounding rather foreign; however, e.g. "systolic overload".

As the title promises, physical examination is dealt with fully, although, as I often find, it sets a standard that is quite impossible for the mere mortal to reach in practice.

Therapeutics are dealt with in a haphazard, and hence easily forgotten, manner. The remarks are accurate and full of practical common-sense, but the pharmacology is all out of order. The book is not unusual in this, however.

What this book gains by its smaller size, readability and reasonable price compared with the larger books is quite unnecessarily cast away, I feel, by the author's deliberate and declared rejection of descriptions of pre-surgical diagnostic techniques, e.g. cardiac catheterization. Surely it is just the student who has the interest (and spare cash!) to buy this book, who will want this information in particular, which he cannot find in the ordinary text books.

D. E. P. SHAPLAND

SPORT

GUY'S HOSPITAL RUGBY FOOTBALL CLUB—TOUR, 1967

For the first time in five years, the Rugby Club managed to arrange an end-of-season tour. Forsaking the traditional tour venues of the West Country and Wales, we travelled North-west to undertake the ambitious task of playing Fylde, Waterloo and Vale of Lune in the space of four days. After such a successful season there seemed no reason why we should not approach such a programme with confidence.

GUY'S v. FYLDE

Monday, 3rd April, 1967
Result: lost 3—14

With a strong wind blowing off the sea at their backs, Guy's started their tour against a useful Fylde side, containing two international forwards in Rowell and Purdy. Guy's had the better of the early exchanges with Elliott and Swift gaining ground with sensible kicking, and the threequarters combining well to put Beacham away twice on the right-wing. The pattern soon changed as the Fylde pack came more into the game but the Guy's defence at this stage was sound. An injury to Neville mid-way through the half was a severe blow to the team and from then on the forwards were unable to hold their own in line-outs or set-pieces. As a consequence, the backs saw little of the ball and were unable to take advantage of the wind. There was no score at half-time.

After the interval, Guy's found difficulty in containing the Fylde pack, who drove the ball down field at every opportunity, well supported by their halves. The defence wilted under the pressure and a reluctance to tackle or fall on the ball led to Fylde scoring four tries in 20 minutes, of which one was converted. Guy's only scoring effort was a bout of interpassing between Beacham, Davies, Williams and Swift, after a break by Kingdon from a line-out. For the rest of the half the play was uninspired and both sides made far too many mistakes. Elliott kicked a penalty goal in the last minute for Guy's.

The injury to Neville undoubtedly undermined Guy's efforts in this match, and it was perhaps asking too much for the team to play well after a 250-mile drive.

B.J.R.

The match against Waterloo on Tuesday was regarded as the main match of the tour. Unfortunately, Neville was injured and Kingdon had an infected foot, thus depriving us of two of our biggest forwards. This was offset, however, to some extent by the return of Thorburn and Ross, fresh (?) from touring in France with B.U.S.F.

GUY'S v. WATERLOO

Tuesday, 4th April, 1967
Result: lost 3—8

The touring party arrived at Waterloo indecisive as to what the side to play would be. However, eventually organised, Guy's kicked off with great fire and determination.

Although winning possession in loose and set pieces, scrappy play tended to smother the ball and rarely was possession truly utilised. With territorial advantage throughout the first half, Guy's failed to capitalise on this, and both orthodox and unconventional moves were brought to a halt by the covering of the experienced Waterloo back-row. As so often happens, the hard-running Guy's wingers saw little of the ball.

Cockburn skilfully dominated the line-outs and Hey took four strikes against the head in the first half. The other notable feature of the first half was the ferocious tackling of the Guy's centres, especially Lewis.

Waterloo began the second half with a change of tactics: making use of the following wind they sent high-raking kicks deep into Guy's territory. (A move that Guy's could have well used in the first half—especially with a hesitant Waterloo full-back.)

The first score came when Elliott found himself alone after making a break from the Guy's twenty-five: the Waterloo back-row heeled the ball on before a loose maul had formed and went over for a try, narrowly beating the Guy's defenders to a touch down. The try was converted. Almost immediately Waterloo were awarded a further try—Guy's drove the ball and heeled magnificently from a loose scrum but Swift's pass was intercepted by a Waterloo wing-forward advancing from what was later acclaimed by both sides as an offside position. Alas, the referee did not!

Guy's vainly tried to fight back and their only real scoring move seemed eminent when Logan broke loose with the ball but failed to connect with Price early enough.

Guy's were finally rewarded by a penalty goal kicked by Elliott. However, this was no adequate reward for a game which Guy's could well have won.

L. J. TURNER

GUY'S v. VALE OF LUNE

Thursday, 6th April, 1967
Result: lost 6—9

The last match was approached with guarded confidence, knowing that Vale of Lune were a weaker side than the other two, but also realising that we needed to record one victory in the North West. The Guy's team showed a number of unusual features with J. E. Davies again 2nd row, Elliott at centre, and Swift on the wing!

The match was played at the picturesque ground at Powderhouse Lane, Lancaster, before a crowd of approximately 200. Alas, there were to be no fireworks on this particular evening!

Guy's were again invited to take advantage of the wind in the first half, and a long kick-off saw them into their opponent's "25". After two minutes the home side were penalised at a scrummage and Elliott kicked the points. The play was scrappy at this stage and Guy's were unable to make full use of the wind, due to the home side's back-row disrupting our inexperienced half-back combination. Also the centres were hurried into mistakes by their opposite numbers. After 20 minutes, Ross showed typical opportunism and resource when he kicked a loose ball, in his own half, passed the

full-back. He cleverly outwitted the cover defence by back-heeling the ball as it was about to go into touch, and picking up to score in the corner. The conversion attempt failed. Vale of Lune moved the ball down the line slickly but their efforts came to nought due to the covering of Williams, Thorburn and Curson. At half-time the score was 6 points to nil.

In the second half, Swift moved to scrum-half but could do little with the ball he received. The Vale half-backs kicked deep into the Guy's half; W. W. Davies spending most of his time retrieving the ball from beyond his deadball line. After 15 minutes they reduced the deficit with a drop goal from 30 yards and then soon after levelled the scores with a penalty from 40 yards. The game almost got exciting at this point as Guy's went all out to regain the lead. Beacham almost went through the centre; Thorburn and Williams made ground from set pieces; and Ross could have been put away had the ball travelled down the line quickly enough. The pressure brought a series of penalties on the Vale "25" which were judged unkickable in the conditions. The moves from the short penalties met with their usual success and the scoring opportunity was lost. Vale reasserted themselves and from a line-out in the Guy's "25" their stand-off jinked through the pack to score in the corner without a hand being laid upon him.

There was little time left for a comeback by Guy's and most of the spectators were relieved to hear the final whistle.

B. J. ROWLANDS

The success (or failure) of a tour cannot be judged solely on results on the field. Using such criteria, ours was a disaster. In all three games we were handicapped to some extent by injury, but also we failed to make full use of the wind in the first half on each occasion. We were a little bewildered by some of the referee's decisions in all three games. It seems that there is a regional variation in the interpretation of the offside law, and the loose mauls are never allowed to develop, so that it is difficult to launch second phase attacks.

One pleasing feature of the tour was the form shown by younger members of the club with little or no 1st team experience when playing against first-class opposition. The experience thus gained by them will be useful in years to come.

Socially, the tour was a great success and may have accounted in part for some below par performances, and many memorable incidents will be looked back on and talked about in the future.

RUGBY SEVEN-A-SIDE

Both the U.H. Sevens and the Preliminary Round at Beckenham of the Middlesex Sevens showed Guy's unable to find their feet before they were out of the competition.

Defeated by St. Barts in the 2nd round of the U.H. Sevens (the eventual winners), Guy's improving slightly succumbed to Blackheath, who with London Scottish qualified from Beckenham to appear at Twickenham.

Guy's lacked both the serious training and mental aptitude that is ominously employed by the first-class clubs. It is much regretted that having so relentlessly endeavoured to reinstate Guy's as a leading London Club this season that their effort should have waned in this most glamorously rewarding competition.

CRICKET CLUB

Last year the Cricket Club had a fairly successful season, recording notable victories over some of London's leading clubs, amongst which Hampstead and Teddington stand out. Unfortunately, we were knocked out of the United Hosiptals Cup in the semi-finals.

The 1967 season, which opens on April 29th with a fixture against Beckenham, sees the introduction of four new fixtures, Putney Eccentrics, R.N.V.R., Enigmas and Chichester Priory. The Dover-Highland Court week-end has been reintroduced and we are again touring in West Sussex.

Our chances in the Cup this year must surely be better than for several years. We have several quite useful freshers this year who will add useful support to the already established players such as Appleby, Crafts, Butchey, Silk and Beacham.

After weekly indoor nets at Crystal Palace during the winter, we are now practising in the nets at H.O.P. and looking forward to an enjoyable and successful season.

R.K.F.C.

DIARY

CRICKET.

April. 29th—Beckenham. 2.30. Home.
30th—Horsham. 2.30. Away.
May 3rd—R.N.V.R. 2.30 Home.
6th—Putney Eccentrics. 2.30 Home.
9th—London Hospital. 11.30 Away.

PAIGNTON FESTIVAL

Most of the team left Guy's early on Thursday morning for Paignton to avoid as much traffic as possible. We congregated at our hotel in the evening and after supper started the tour by renewing some old acquaintances at the Polsham Arms.

Our first game on Good Friday, against the Bath Buns, started off at 10.15 a.m. We were beaten 2—0. This was because we had not played together as a team before and it was quite clear that we needed same time to get adjusted to each other. We were due to play against the Pussdogs in the afternoon, but a late change of venue, which the captain unfortunately was not aware of, caused the cancellation of the fixture.

On Saturday morning we played the Clee Villians at Torquay. We played a better game and were satisfied with a 0—0 draw, hoping for a win in the afternoon. This, however, was not to be, and we were beaten 2—0 by the Wolves, a straigish 1st XI from the Midlands.

After a somewhat riotous time on Saturday night, about half the team read the Sunday papers all morning while the rest, in need of further exercise, apparently played soccer on the beach. In the afternoon we played the Grey Nags at Queens Park, the headquarters of the festival. We drew 1—1. This result included the first goal scored at Paignton for two years. Compared with previous games we played good attacking hockey, such a contrast to the defensive attitude that we had previously adopted.

After a quiet evening for some and a more questionable one for others, we played the Arrowheads at Tweenaway on Monday morning. The pitch was in poor condition, and although we scored first we were not able to repel the strong Arrowheads' forward line and we were eventually defeated 4—1. This was the biggest defeat of the tour.

Our last match was played in the afternoon at Dartmouth College. We finished well, losing only 1—0 to the Buffaloes, who were one of the top teams at the festival this year. Everybody played above themselves, producing a performance rivaling the game against the Grey Nags at Queens Park.

In summary, we played six games; drawing two and losing four. On paper we went down to Paignton with a weak side, but combined to play possibly the best hockey that many of us had ever played. Together with the Anaphalactics (St. Thomas' Hospital 2nd XI), we were the only 2nd XI teams at the festival. We were able to play on even terms with all the opposition that we encountered. In the forwards, Owen played consistently well, ably supported by Clark, Chase and Kirby. Calder was outstanding in goal, aided by Loomes who played a solid game at full-back. Special mention must be made of Topliss and Martindale, two freshers from the 3rd XI, who both improved out of all proportion at Paignton; this augers well for the future.

Thanks must go to Knight who umpired all our games at the festival, not to mention all the St. Thomas' games and four others as well.

Results

Spirochaetes v. Bath Buns. Lost 0—2.
Spirochaetes v. Clee Villians. Drawn 0—0.
Spirochaetes v. Wolves. Lost 0—2.
Spirochaetes v. Grey Nags. Drawn 1—1.
Spirochaetes v. Arrowheads. Lost 1—4.
Spirochaetes v. Buffaloes. Lost 0—1.

Guy's: D. Silk (Capt.), C. Calder, R. Loomes, T. Sutherland, I. MacKenzie, M. Bridger, B. Martindale, J. Topless, P. Kirby, R. Chase, T. Owen, R. Clark. Umpire, M. Knight.

D. B. A. SILK

RUGBY

GUY'S v. TREDEGAR

Result: lost 6—11

The last match of the season was at H.O.P. against Tredegar, this promised to be a close game since both sides had had a very successful season with less than 10 defeats. However, this was not to be Guy's day for they rarely combined as a team to produce the effort or enthusiasm which has been responsible for their best season since the war, and showed the effects of the Easter Tour from which they had just returned.

The first twenty minutes was all Guy's, and they scored within 90 seconds when the ball was well heeled from a loose maul and an orthodox passing movement sent Price in at the corner. Guy's failed to convert but maintained play in the Tredegar half until the half-hour when Guy's play became more lackadaisical and the Tredegar pack and half-backs asserted themselves. Guy's were driven back, their winger, following a good movement, scrambled over in the corner. The conversion failed, but continual pressure allowed their fly-half to drop a fine left-footed goal just before half-time.

In the second half, Guy's played up the slight slope and against the blustery wind, but although they pressed hard they never appeared to have the ability or plans to crack a hard defence; they relied too frequently on speculative kicks ahead or orthodox passing movements. The seal was finally set when a dropped pass in the Tredegar "25" was pounced upon and kicked ahead and over the Guy's line between the posts; this was duly converted. Finally, in the closing minutes, Beacham scored in the corner after sustained Guy's pressure, the game ending shortly afterwards.

Of individual performances, Hey, the 19-year-old Kent hooker, took six heads off his opponent, ably supported by Davies whose play in the loose in recent weeks belied his non-insignificant midriff. Neville, in the line-outs, secured good ball and Curson, in the back row, again showed his bast improvement with another sterling performance. The threequarters lacked their usual fluency posibly because of hesitancy between the half-back. However, Ross—until injured—and Beacham had good runs. Elliott, at full-back, was off-form with his place kicking but his excellent all-round play again underlined his potential. Thus Guy's ended the season with over 500 points to their credit and on only two occasions did they fail to score.

It would not be inappropriate to mention that John Davies and Alan Kingdon together played their last game for Guy's Hospital. Both Kent county players, they have played every match for Guy's—barring injury—since 1961 and 1962 respectively, and John Davies last year led the Cup-winning side. Playing in the front and second row, they often held together a losing

pack and both have set an example in team spirit, sacrifice and loyalty which will be hard to emulate. Their athletic prowess and social capacity will also be sorely missed by their drinking companions!

H. C. SHARP

HOSPITAL INFORMATION

APPOINTMENTS VACANT

GUY'S HOSPITAL DENTAL SCHOOL

Applications are invited for the appointment of **Senior Lecturer (full-time) in the Dental Department for Children,** with duties to commence as soon as possible. Salary in the scale £2,590 x £115 to £3,050 (bar); £3,165 x £115 to £3,395, with superannuation. Forms of application are obtainable from, and should be lodged with, the Dean, Guy's Hospital Dental School, London, S.E.1, not later than **Friday, 19th May, 1967.**

GUY'S HOSPITAL, S.E.1.

Applications are invited for the post of **Temporary Registrar in Orthopaedics and Casualty,** with appointment from 19th June to 30th September, 1967, in the first instance. Forms of application are obtainable from the Superintendent, Guy's Hospital, S.E.1, and should be returned not later than **15th May, 1967.**

GUY'S HOSPITAL, S.E.1.

Senior House Officer in Pathology required immediately for St. Olave's Hospital and New Cross Hospital Laboratories. Post registered for Diploma in Pathology. Good training facilities. Resident or non-resident. Applications in first instance to the Group Pathologist, St. Olave's Hospital, Lower Road, S.E.16, as soon as possible.

MILLER GENERAL HOSPITAL requires a **Senior House Officer in General Medicine,** from June 1st for a period of six months. Applications with the names of two referees should be sent to the Superintendent, Guy's Hospital, S.E.1, by **May 6th, 1967.**

GUY'S HOSPITAL

JUNIOR STAFF APPOINTMENTS, 1967-68

Applications are invited for the following appointments to the Junior Staff of Guy's Hospital, commencing on 1st October, 1967, for the session 1967-68. Forms of application are obtainable from the Superintendent and should be lodged with him not later than **13th May, 1967:—**

Anaesthetics	
Senior Registrars	3
Registrars	3
Registrar	*1
At St. Olave's and New Cross Hospitals	
Registrars	2
Cardiology	
Senior Registrar	1
Junior Registrar	1
Child Psychiatry	
Senior Registrar	2
Registrar	1
Clinical Pathology	
Senior Registrar	**1
Registrars	3
Registrar (Haematology)	1
Dermatology	
Registrars	2
Diagnostic Radiology	
Senior Registrars	2
Registrars	2
Trainee Registrars	2
Ear, Nose and Throat Surgery	
Senior Registrars	**2
Registrars	†2
Dialysis Unit	
Senior Registrar (half-time)	1
Registrar	1
Endocrine and Radioisotopes	
Registrar	1
Medicine	
Senior Registrars	**2
Registrars	3
Junior Registrars	4
At New Cross Hospital	
Registrar	1
At St. Olave's Hospital	
Registrar	1
Junior Registrar	1
Neurology	
Senior Registrar	1
Registrar	1
Obstetrics	
Registrar	1
Ophthalmology	
Senior Registrar (P/T)	1
Registrars (P/T)	2
Junior Registrar	1
Orthopaedic	
Registrar	1
At St. Olave's Hospital	
Registrar	1
Orthopaedic and Casualty	
Registrar	1
Paediatrics	
Senior Registrar	1
Registrar	*1
Physical Medicine	
Registrars	††2
Psychological Medicine	
Registrars	3
Radiotherapy	
Senior Registrar	1
Registrar	1
Surgery	
Senior Registrars	2
Registrar	1
Junior Registrars	‡4
At St. Olave's Hospital	
Registrar	1
Thoracic Surgery	
Senior Registrars	2
Registrar	1
Urology	
Senior Registrar	1
V.D.	
Registrar (part-time)	1

***Registrars under the Exchange Scheme**

These appointments are under the Exchange Scheme and will be made jointly with the South-East Metropolitan Regional Hospital Board and Guy's Hospital, in the following subjects with a two-year tenure of the posts. Applicants will be expected to spend one year at Regional Hospitals in the Groups mentioned:—

Anaesthetics—Brighton and Lewes Group.
Paediatrics—Brighton and Lewes Group.

****Senior Registrars under the Exchange Scheme**

These appointments are under the Exchange Scheme and will be made jointly with the South-East Metropolitan Regional Hospital Board and Guy's Hospital, in the following subjects with a four-year tenure of the posts. Applicants will be expected to spend periods as stated in the Regional Hospitals in the Groups mentioned:—

Clinical Pathology—Lewisham Group (two Years).
Ear, Nose and Throat Surgery—Lewisham Group (one or two years).
Medicine—Lewisham Group (one year).

†Registrars in Ear, Nose and Throat Surgery

Appointments to these posts may involve spending one year at Lewisham Hospital under an Exchange Scheme with the South-East Metropolitan Regional Hospital Board.

††**Registrar in Physical Medicine**

This appointment will also involve duties at New Cross and St. Olave's Hospitals on a day-to-day basis.

‡**Junior Surgical Registrar**

Two of these appointments will be two-year rotating appointments with duties for six months at the Maudsley Hospital. Appointment for one year in the first instance—renewable.

GUY'S HOSPITAL MEDICAL SCHOOL JUNIOR STAFF APPOINTMENTS, 1967-68

Applications are invited for the following appointments to the Junior Staff of the Medical School for the session 1967-68, commencing 1st October, 1967. Forms of application are obtainable from, and should be lodged with, the Dean, not later than **13th May, 1967.**

Chemical Pathology	
Anderson Demonstrator	1
Lecturer	1
Anatomy	
Junior Lecturers	3
Junior Lecturer (part-time)	1
Medicine	
Lecturers	2
Junior Lecturer	1
Poulton Fellowship	1
Pharmacology	
Junior Lecturer	1
Surgery	
Lecturers	2
Student Health Service	
Assistant to the Director (part-time) ..	1

Applications are invited for the following Fellowships and Studentships. Applications should be made not later than **13th May, 1967,** on a form to be obtained from the Dean, Guy's Hospital Medical School.

The Beaney Scholarship for Materia Medica

Candidates for the Scholarship must have received part at least of their medical education at Guy's Hospital Medical School. The object of the Scholarship is to advance knowledge of Materia Medica (including Pharmacy, Pharmacology and Therapeutics) by supplying the Scholar with the means of carrying on original investigation in these subjects. The Scholar holds the Scholarship for three years and is eligible for re-election. The Scholarship is of the value of approximately £150 per annum.

The Greville Studentship

The Greville Student, who is required to devote himself to original investigation in connection with the subject of Cancer, holds the appointment for a period of two years, renewable annually for a further period of three years, making five years in all. The Studentship is of the value of approximately £40 per annum.

The Lambrinudi Memorial Scholarship

Candidates for the Scholarship should have completed their preliminary training in Orthopaedic Surgery and have held the post of Orthopaedic Registrar in a Teaching Hospital, *and wish to prosecute further the study of* Orthopaedic Surgery in any of its branches, either by way of post-graduate study or travel or by research work in Orthopaedic Surgery. The value of the Scholarship is approximately £110.

The Sir Alfred Fripp Memorial Fellowship

The Sir Alfred Fripp Fellow is required to promote the advancement of knowledge and research in Psychology, more particularly through the study of children and/or in disease. The Fripp Fellow is allowed opportunities for study in the Paediatric Department and in the Department of Child Psychiatry and is required to submit with his or her application a definite scheme of advanced study or research to be carried out during the tenure of the Fellowship. The value of the Fellowship is approximately £500 per annum.

J. C. HOUSTON,
Dean

April, 1967.

PERSONAL

ASSOCIATE/ASSISTANT required from 1st May in South London. Usual clinical freedom, surgery assistance and percentage remuneration. *Tel. Pol. 4340.*

DENTAL ASSOCIATE/ASSISTANT with view to partnership required urgently by Guy's Dental Surgeon in Bexleyheath. Phone: 01-303 4077 or 01-303 8815 (evenings).

SAN FRANCISCO/LONDON ACCOMMODATION EXCHANGE. American Professor on a Fulbright Fellowship to Guy's wishes to exchange four-bedroomed, two reception-roomed ranch-style house overlooking Bay and Bay Bridge for a two to three-bedroomed house or flat within easy access to Guy's. September, 1967—June, 1968. Professor Merril, Director Communications Office for Research and Teaching, University of California, San Francisco, California 94122, U.S.A.

CHANGES OF ADDRESS

Dr. Clive Barrett, Kenmare Road, Greenpoint, Gosford, N.S.W., Australia.

Dr. and Mrs. D. P. Braid (Jill Ransome-Wallis, L.D.S.), Ortona, 41, Charlotte Street, Helensburgh, Dunbartonshire.

Wing-Commander D. J. Stoker, M.R.C.P., R.A.F., R.A.F. Hospital, Cosford, Wolverhampton, Staffs.

Dr. and Mrs. A. H. Sunner, 16, Rectory Road, Wokingham, Berkshire. (Tel. Wokingham 1788.)

ENGAGEMENT

HYATT WILLIAMS — DINWIDDY — The engagement is announced between Robert Hyatt Williams and Geraldine Dinwiddy.

BIRTHS

ASHBY—On April 6th, 1967, at home, Orchard House, 4, Valley Road, London, S.W.16, to Kathleen (née Allsopp) and Peter Ashby, a daughter, Rosamund Jane, a sister for Mark.

BOGGIA—On 30th March, 1967, to Rosemary (née Wilson) and Roderick Boggia, B.D.S., L.D.S., a son, Mark Peter, a brother for William.

CAVENDISH—On 30th November, 1966, at Stepping Hill Hospital, to Jean (née Willis) and Dr. Michael Cavendish, a daughter, Fiona Jane, sister for Andrew and Paul. (43, Parklands Way, Poynton, Cheshire.)

MARRIAGE

KEATS—WAKELIN—On Saturday, February 18th, at St. Clements Danes, Strand, John Keates to Jenny Wakelin.

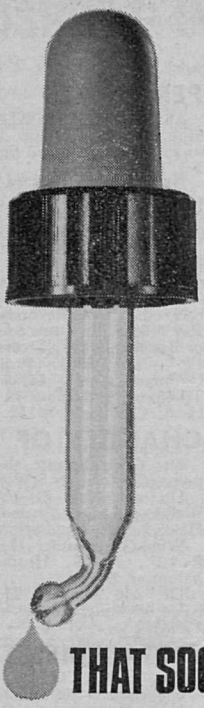
DEATHS

ROWLAND HILL—On 14th April, 1967, T. Rowland Hill, M.D., F.R.C.P., of 14, Wimpole Street, W.1, husband of Sybil (née Cumming) S.R.N.

TRAILL—Dr. Ralph Robert, on April 5th. M.A.(Camb.), M.R.C.S., L.R.C.P.(Lond.) 1916, M.B., B.Ch. 1922. Westways, West Terrace, Budleigh Salterton, Devon.

We would like to remind our readers that all copy for inclusion in the Gazette must be received eight days before the publication date.

Personal notices one shilling per word (Minimum £1. 1s. 0d.)
Birth, Marriage, Death and Change of Address notices are without charge to subscribers.
Non-subscribers will pay £1. 1s. 0d. for all notices other than Personal.



THE DROP THAT SOOTHES THE INFECTED EAR

'Otosporin' rapidly destroys virtually *all* bacteria commonly found in ear infections, reduces irritation, inflammation and pain. 'Otosporin' brand Drops contain polymyxin B sulphate, neomycin sulphate and hydrocortisone in a bland suspension designed to facilitate penetration. Issued in bottles of 5 ml.

'OTOSPORIN'

Burroughs Wellcome & Co. London
(The Wellcome Foundation Ltd.)

GUY'S HOSPITAL GAZETTE

EDITORS D. S. ROBINS and C. B. BROWN
SPORTS CORRESPONDENT J. G. PAYNE
NURSING CORRESPONDENT E. A. MALPAS

FORTNIGHTLY TWO SHILLINGS VOLUME 81 NUMBER 2056

The opinions expressed in these columns are solely those of their authors and are not to be taken as the views of the Hospital as a whole.

PASSIM

Christopher Robin's Alices

Owing to administrative difficulties—the nursing crisis remember, whatever happened to Baby Florence?—restrictions have been put on the excuses nurses, during their spell of nights "on" while on night duty, may use specially to have a night off duty. Four occasions, however, remain. All the young women who, to celebrate coming of age, may have the night off, but only if it is they themselves who are achieving that momentous milestone. Secondly, mind you only once in the average three-month period of night duty, they may accept an invitation to be a bridesmaid (at night?). Frills, colours, sighs, tears, longing envious pride, how marvellous, how lucky, especially that Amanda and Reginald were able to change the date for me so that I could perform at both weddings on the same night (*again*). To be fair, even parents' silver weddings, etc. are favoured occasions when the rule of not asking for the night off duty may be broken. Finally, M'Lords, Ladies and Gentlemen, each and every nurse is given special dispensation to forgo her desperate desire to work that night if the family has a special engagement such as a visit to Buckingham Palace (also at night?).

The extenuating circumstances and examples will probably still be up on the Nurses' Home notice board if you hurry, for that is the nicest touch of all—the above is absolutely true.

Accipere Quam Dare

With May Day quietly past we print a letter in this issue on a subtle variation of breaking the 5th Commandment. As social welfare improves, stealing paradoxically increases. Many people at Guy's (which is by no means in a worse predicament than any other teaching hospital) have been frustrated by the overwhelming number of measures that are in force to maintain security. Devious routes through hospital grounds after 11 p.m. owing to a complicated system

of fastened gates; locking of the Students' Club premises after the same arbitrary hour*; the absolute necessity of locking up valuables, including pennies, in Theatres' lockers; these are but a few.

As the letter suggests, there is every reason to believe that the offenders are most likely not to be members of the Hospital's students or staff. That these shadowy people are competent is unquestionable, as strange visitors creaking along Guy's House passages at night and pathetic notices like "Will the person who removed my briefcase by mistake . . ." appearing with sickening regularity bear witness. Those in charge of maintaining security have an extremely difficult task on their hands, for a hospital, unlike most other large institutions, is by its name if not its nature a place where the right of admission is difficult to reserve.

Even were such right exercised, however, there would remain the problem of petty larceny amongst those who normally work in the hospital. Education and financial welfare are not enough; recent evidence supporting the claim of a chromosomal disposition towards crime of a predominantly materialistic nature suggests that some form of engenic procedure may eventually be required if crime of this sort is to be eradicated. But the rôle of education is not yet exhausted. At the risk of appearing pedagogues, we must continue to warn people of the prevalence of petty thieves in their midst. It is a sad duty, for if successful it promotes suspicion, cautiousness and often considerable inconvenience; if even more successful, however, it will, like most campaigns, bring about its own demise when the aims have been achieved. The notice boards can serve better functions than to carry pathetic little notices which state, "Will the person who. . . ."

Revolution or Evolution ?

All agree that change for the sake of change often results in the loss of something whose use has stood the passage of time. Yet how often does one see this premise falsely proposed in the justification of moves to prevent change. The word is "often" not, as is mistakenly implied, "always". Most of those who have vested interests prefer the *status quo,* however strong the arguments for change. There is no such state as the static, there is either a movement forward or a slipping back.

Revolution in most cases nearly always causes some damage to

---

* It is difficult to see why this time cannot be changed to 11.30 or midnight, which will allow easier return journeys from the Miller and to the College and will remove the ridiculous switching off of the students' television half-way through the often eminentlly viewable late night programmes. What won't happen before 11 p.m. will not necessarily happen before midnight.

the useful, although some argue that the good obtained outweighs that which was destroyed in the process. The "evolutionists" counter by pointing out that what is gained slowly is more practicable, since it is adapted with time to the needs imposed upon it. And so the pros and cons are bandied about with examples quoted to illustrate favourably the particular proposition.

But there are simple things which sometimes present themselves for consideration, in which the evidence proposed in the name of change is so obviously overwhelming that most would agree and let the matter quickly pass. And yet, on occasions, the suggested change becomes charged with menacing overtones and all take fright and shelve it. Such it is with white coats for clinical students.

For many years students here and there have made the suggestion for dressers and clerks to wear white coats while working on the wards, each with a name tag to identify himself, and yet still no agreement has been reached by those with authority. The capital cost of two or three white coats and the running cost of cleaning them once a week is far smaller than that of purchasing one or more suits and having them cleaned once a month plus depreciation.

This week we publish a letter with this proposal for white coats and sincerely hope that those in favour will in some manner express their support so that the evolutionary processes may be put into effect and a revolution be avoided.

Co-rrespondents

We welcome with this issue a return to the enlarged correspondence column. It would appear that more readers are realizing its potential as an excellently lazy way of writing an editorial: denouncing, praising, informing and amusing without having the spade work. The Editors are particularly grateful, if only that the task of choosing suitable titles to the letters is one that has for long provided a relaxing digression from the tedium of arranging and pasting-up material on every other Monday evening. Please continue; one day they may be Collected.

Antiquaries and ?

We begin in this issue a minisection of extracts from *Gazettes* of 1877 and 1917. The past is always interesting, as our opening extract from Passim of May, 1877, was at pains to point out, particularly as it demonstrates how difficult it is to see what is new and what is old.

"Side by side with this love of the unpractical has grown up an ever-increasing scepticism, which defies all traditions of the past, leaving to antiquaries and chinomaniacs the reverence for everything old."

Prizes may be given to the reader who can furnish us with the figurative translation of "chinomaniac". Further prizes for the literal translation may well be given by the Shorter Oxford Dictionary.

It is with deep regret that we record the death of Dr. Keith Norman Dunn after a climbing accident near Lands End. Having qualified from Guy's only last year he was well known by many of his contemporaries at present on the House.

We offer our warmest congratulations to Mr. John Maynard, who has been appointed to succeed Mr. Nils Eckhoff as Consultant Surgeon in August, 1967.

We also congratulate Dr. B. J. Cremin on his appointment as Consultant Paediatric Radiologist at the Red Cross Memorial Children's Hospital and Groote Schuur Hospital, Capetown. A holder of Guy's Blues in Rugby and Boxing, he would welcome contact with any Guy's men working in Capetown.

GUY'S DIARY

MAY			EXHIBITION: In the Gordon Museum: "Catheterization."
15th	M.	1.00	Clinical Lecture. Mr. TOMKINSON. "How To Conceive."
16th	Tu.	5.00	Medical Genetics Series: Physiology Theatre. Dr. A. GRANT. "Blood Group Genetics."
19th	F.	1.00	Clinical Lecture. Mr. WATSON. "The Primary Glaucomas."
22nd	M.	1.00	Clinical Lecture. Dr. JOSEPH. "Indication for Surgery in Congenital Heart Disease."
		5.00	Medical Genetics Series: Anatomy Theatre. Prof. S. COHEN. "Immunogenetics."
23rd	Tu.	1.00	Clinical Lecture. Mr. KILPATRICK. "Tuberculosis of the Urinary Tract."
25th	Th.	5.00	Neurosurgical Round. Mr. SCHURR. Clinical Theatre.

NOTICES

Notice is hereby given that the elections for the Guy's Student Medical Education Committee will be held on Monday, May 15th, between 9.30 a.m. and 5.00 p.m. A ballot box will be placed in the East Wing and all medical students at Guy's are entitled to vote. The Annual General Meeting will be held on Friday, May 19th, at 5.00 p.m. in the North Common Room, East Wing. All medical students are entitled to attend.

R. H. S. LANE,
Chairman

Guy's Hospital Nurses' League

League Journal, 1967

Copies of the new Journal are available in Matron's Office for any member of the Consultant Staff who would like to have one.

ANNE M. JOHNSON,
Matron and Honorary Secretary,
Guy's Hospital Nurses' League.

An Appreciation

Mr. G. F. GIBBERD

C.B.E., M.S., F.R.C.S., F.R.C.O.G.

Mr. Gibberd, who retired on 18th April, will be greatly missed at Guy's and elsewhere, not only for his great distinction as an obstetric surgeon, but as a man who from his earliest years stood out as a great personality among his fellows.

He entered Guy's as a Student in January, 1919, having made his intellectual mark at school. He qualified in 1923, and after "Clinical" was appointed A.H.S. to Mr. E. G. Slesinger, and later H.S. to Mr. F. J. Steward; the latter especially had a distinct influence on his approach to the practice of medicine, though Mr. Gibberd must always have been meticulously thorough and thoughtful in his care of patients. After a period as H.S. at the City of London Maternity Hospital, where in those days, much of the emergency obstetrics was a reminder of the last century, he returned to Guy's in 1925 as registrar in the Department of Obstetrics and Gynaecology, and in 1931 he was appointed assistant surgeon in that department. While a registrar he passed the examination for the F.R.C.S. Eng., and the M.S.Lond.; for the latter he worked of an evening with the late Professor Spurrell, and they must have greatly helped one another, though Mr. Gibberd would always have it that Spurrell did the reading and he only absorbed concise knowledge, distilled by that great teacher.

Gibberd himself was a great teacher also, even from his earliest days, and as the years passed by, this faculty developed, until his renown spread far beyond Guy's and Queen Charlotte's Hospital, where he was also appointed to the staff as a young man. It is as a patient and stimulating teacher by word of mouth on all sorts of occasions, day and night, with a unique technique of his own, that many will remember him, but he was also unusually clear with his pen, and his "Short Textbook of Midwifery", which appeared in 1938, immediately took its place as a very successful book for students; it has since run to many editions.

Mr. Grant Massie used to say that when Gibberd brought his mind to bear on a problem: "It was like turning on a searchlight", and that: "He can see further through a brick wall than most". It is this faculty that had been recognised so widely, not only on Committees at Guy's, Queen Charlotte's and the Samaritan Hospital, but at the Ministry of Health and elsewhere; if a discussion is getting out of hand and away from the point, and possibly a little acrimonius, then is the time that Gibberd always steps in, and after one or two points made in a typically amusing way, he will demolish any false arguments and establish a commonsense point of view—all done with the greatest courtesy.

He is always listened to with great respect, for his integrity and clear, logical mind have long been apparent to all.

Gibberd's public service to the profession has been enormous. In 1928, he and Mr. (now Sir) Arnold Walker were appointed examiners to the Departmental Committee on Maternal Mortality, and analysed some 6,000 confidential enquiries to determine what were the factors, avoidable or otherwise, responsible for these maternal deaths.

In 1938 he became Honorary Secretary to the Royal College of Obstetricians; as such he followed Sir William Fletcher Shaw, who had done so much to found the new College (not then Royal). During the following

formative years Gibberd put in an immense amount of work for the College, which has since held almost as warm a place in his heart as has Guy's itself. In 1952 he was appointed the first Sim's-Black Travelling Professor of the R.C.O.G., and as such visited and lectured in many of the Commonwealth Countries. He himself saw and learnt a great deal, which, with his prodigious memory has been a source of interest ever since. In 1958 he was elected Vice-President, R.C.O.G.

Further, he was a valued member of the Maternity Services (Cranbrook) Committee and of the Medical Advisory Committee of the University Grants Committee. In recognition of his many services he was made a C.B.E. In recent years he has been a Governor of both the Hospital and the Medical School. During the war, the Army claimed Gibberd and he served in the R.A.M.C. in North Africa and Italy.

Gibberd has always felt greatly indebted to A. J. McNair, who did so much to found the present Department of Obstetrics, and ante-natal care at Guy's, and there is no doubt that McNair must have influenced him a lot in his early career. He in his turn has greatly influenced his junior colleagues and many others, who owe much to him, not only for his example and teaching, but for many kindnesses. While surely well aware of his own ability, Gibberd has always remained humble, unselfish and unassuming, and ready to listen to juniors, provided they are sincere and are talking to some purpose; he has always made a point of consulting the midwifery sisters on many problems, and no one could have been more conscious of the big part they play in the teaching and practice of obstetrics.

Since we, his friends, have now had to say farewell to Fred Gibberd from the active staff, it is good to think that he will have time to return to his many interests, such as the study of books on diverse subjects, or hobbies such as making reproductions of antique furniture. We wish him and Mrs. Gibberd many happy years at Dulwich, and look forward to often seeing them both at Guy's which has played so great a part in their lives, and where he has made so great a contribution.

J.B.B.

REPORT

The Guild of Ex-Patients and Friends of Guy's Hospital held their 18th General Meeting in the Physiology Theatre last week (26th April).

Miss MacManus (an ex-Matron of Guy's), President of the Guild, came over from Ireland to take the chair.

It was reported with deep regret the death of Mr. J. C. Carlisle (Hon. Treasurer to the Guild from 1956-1966), and the resignation of Miss T. Sidney (Secretary to the Guild since its inception in 1933).

Mr. A. C. Edwards was elected Hon. Treasurer on the 30th April, 1966, and Mrs. M. B. Coleman, Secretary, on July 1st, 1966.

The Hon. Treasurer, in presenting the Accounts, reported that the Guild was still very healthy financially. It was mentioned that in 1965, £1,706 had been used to purchase Oral Radiology equipment for the Dental Department and in 1966, £800 had been given to the Cardiac Department to purchase a Cardio-Projector Machine for diagnosing cardiac conditions, and £2,500 towards the cost of Cardiac Monitoring equipment, in memory of the work of the late Mr. Carlisle.

Dr. P. J. Helliwell, Superintendent of the Hospital, thanked the Guild for the help it gave the Hospital and said a few words about the upheaval that was taking place in the park.

Matron also thanked the Guild for their great help in providing Christmas parcels for patients in hospital, a carpet for Nuffield Nurses' Sitting Room, television sets given to Bright Ward and Nurses' Sick Bay, and a tape-recording machine for eye patients in Barnabas Ward.

THE ART OF ORTHOPAEDICS

by

T. T. STAMM

Orthopaedics has been defined as the art of restoring and maintaining the functions of the locomotor system. Why "the art", not "the science"?

In many branches of surgery it is possible to collect large numbers of comparable cases and to subject the results of treatment to statistical analysis. Advances can then be made on a strictly scientific basis, but this is dependent upon the number of significant variables being small and controllable.

In orthopaedics we are denied this facility, for the number of variables is usually far too great and many of them can only be assessed subjectively.

To take, for example, osteo-arthritis of the hip. When deciding upon treatment one must take into account not only the condition of the joint itself (which is almost infinitely variable), but that of the opposite hip, the knees, and the spine; also the age, sex, occupation, and general health of the patient. Finally, and by no means least, the mental outlook of the patient. In reconstructive surgery the result depends largely upon the intelligent and determined co-operation of the patient—a factor which cannot be defined in statistical terms. In two similar cases one may decide upon arthroplasty in one because the patient expresses his determination to get a new movable joint, while in the other arthrodesis seems safer because he shows limited intelligence and ability to co-operate.

There are also a great variety of operations to choose from and one cannot even compare their results analytically. One cannot, except in the most general terms, compare the results of arthrodesis where the objective is to fix the joint, with arthroplasty which is designed to make it move. It is like trying to compare an etching with an oil painting of the same subject. The comparison can only be subjective in the eyes of the beholder.

In pure orthopaedics the most one can do is to take a single factor, such as the percentage in which bony fusion is achieved by different methods of arthrodesis. Such analyses are helpful and essential, but they cannot give the final answer to the problem of what one should do in each individual case, for one will probably never have seen even one identical case before, much less a series.

The definition given above also includes the word "functions". Although for convenience orthopaedists must deal with disease processes, pure orthopaedics is concerned with function which has been disturbed by injury or disease. It is a failure to understand this concept that so often leads to successful surgery that leaves the patient worse off. It is often tempting to correct a deformity just because it is there and presents a challenge. It is even thought by many, who should know better, that the correction of deformities is the orthopaedist's main job. In fact, in his endeavour to improve function he may create more deformities than he corrects.

The writer was once asked to treat a rheumatoid patient with fixed flexion of both hips and knees. The unfortunate patient was subjected by the inexperienced but enthusiastic surgeon, to four reasonably successful operations. However, as his knees were now straight but still stiff and the hips still slightly flexed he could no longer sit in comfort and in trying to stand inevitably pitched forward onto his face. He therefore had to be subjected to further operations to restore the *status quo*.

Function is extremely difficult to assess. It is primarily dependent upon the relationship between the patient and his environment. Often one must choose between strength and mobility. To return to the hip joint—a labourer requires a strong and stable leg, so arthrodesis may be the best answer, whereas an elderly patient of sedentary habits might be better off with an arthroplasty to make sitting more comfortable, even though the new joint might be weak.

The same problems apply to other joints. For example, arthrodesis of the wrist gives an excellent functional result for most people, but would be hopeless for the left hand of a violinist or the right hand of a car mechanic.

Function, therefore, cannot be defined in general terms, but only in relation to each individual patient. It must, however, always be the first and most important consideration in orthopaedics.

The fascination of orthopaedics lies in the fact that we know that the next patient we see will present a problem that may be familiar but is also probably unique. We shall not be able to refer to the computerised results of a large series of identical cases for the answer, for there may never have been an exactly comparable case if all the variables are considered.

There is one further factor—the surgeon. Neither surgeons nor artists can be expected to be "all-rounders". A Leonardo da Vinci happens but rarely. For most of us it is better that we do an

operation with which we are familiar and can do well, rather than some unfamiliar procedure which might theoretically give a better result. Hence the frequent disagreement amongst surgeons as to the correct procedure in any particular case. Each will favour the operation which in his hands he feels would give the best result.

For these reasons orthopaedics must for a long time continue to give deep satisfaction to humans and despair to computers.

Surgery and Evolution

Humans are not yet humans. They are still not far removed from quadrupeds that have decided to stand upright and become bipeds. It would seem certain that in a short time, say 10,000,000 years, further changes will occur to adapt the human body to its new functions and altered mechanics.

The process has advanced furthest in the upper limb because it was only by the use and development of his hands that man evolved at all. It is only in the shoulder joint that further adaptive changes would seem desirable. In the quadruped the movements required are mainly those of flexion and extension for which the joint is well designed. In order to get his hand where he needs it, man has to be able to abduct his shoulder as well. This movement entails tucking the greater tuberosity of the humerus under the acromion. When performed repeatedly under load this often sets up an inflammatory reaction due to friction. This is the commonest of all causes of pain in the shoulder. The writer devised an operation which he has the temerity to regard as possibly anticipating evolutionary changes. The operation entails moving the whole joint downwards half an inch away from the overhanging acromion, thus avoiding the possibility of friction.

In the spine the adoption of an erect attitude has produced an acute bend in the lower lumber spine, for the pelvis is still inclined forwards as for a quadruped, while the spine has to be bent upright. Thus the whole weight of the body is transmitted to the pelvis as a shearing strain across sloping joint surfaces. This, of course, is why "low back pain" is almost universal. In fact, one can define man as a biped with a pain in its back. The answer is either to tilt the pelvis upwards or to fix the last two vertebrae to the sacrum. It would seem that evolution is working on the latter alternative, for quite often the 5th lumbar vertebra is sacralised. Orthopaedic surgeons take the hint, achieving this fixation with a bone graft.

The hip joint in a quadruped takes one-quarter of the body weight and is designed accordingly. In man it has to take a strain equal to twice the superimposed weight but it has not yet been redesigned to take this greatly increased strain. (See Fig. I). This is the main reason why it is so frequently affected by degenerative changes. Its safety margin is so small that any slight imperfection will lead to excessive wear and tear, for even a perfect joint can only just withstand the overloading to which it is subjected.

FIG I

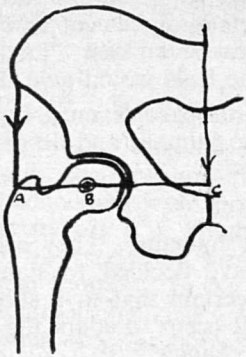


Fig. I. When one leg is taking the body weight the pelvis has to be held horizontal by the downward pull of the abductor muscles on the brim of the pelvis. Since the distance AB is 2 ins. and BC 4 ins., they have to exert a pull equal to twice the superimposed weight and this is transmitted through the fulcrum provided by the hip joint.

When reconstructing a hip joint, surgeons usually try to produce a new joint that is as nearly as possible a replica of the original. It is perhaps not very ambitious or rational to try to reproduce something that is obsolete and wears out so easily.

The writer has tried to design a new joint of simpler mechanics that might be less likely to suffer from excessive load. In cases of bony ankylosis the procedure shown in Fig. II produces a new joint that has large weight-bearing surfaces to reduce the load per square inch; they are horizontally opposed to eliminate shearing strains and as near the mid-line as possible, which again reduces the load (cf. Fig. I). The essential abductor mechanism is also preserved. This type of new joint is now known to last at least 25 years.

FIG II

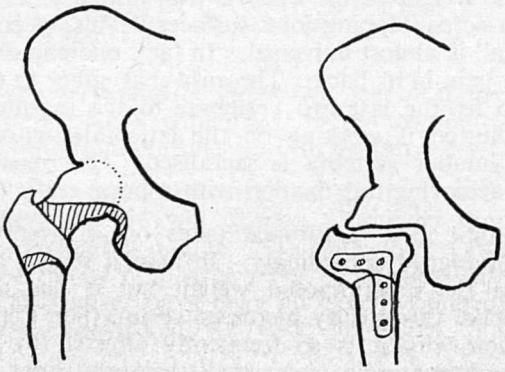


Fig. II. The cross hatched areas of bone are removed. The two portions of the femur are fixed together with a bone plate as shown.

The foot provides the surgeon with at least two opportunities to anticipate evolutionary changes.

(1) The adductor muscle of the great toe is inserted into the base of the phalanx and the lateral sesamoid. It had a useful action on the digit when we had thumbs on our feet. During the evolution of the human foot its function has changed. Using its insertion as its origin, the action of the adductor is to brace the forefoot together through its attachments to the outer four metatarsals. This action could be carried out much more effectively if it were attached to the head of the first metatarsal instead of to the phalanx, and it seems likely that it will migrate there in the course of time. This would also obviate its tendency to produce a valgus deformity of the great toe.

Accordingly, when surgeons are operating to correct a hallux valgus deformity they often transplant the tendon of the adductor muscle into the head of the first metatarsal.

(2) The toes were originally designed as prehensile instruments. This action is no longer required unless one has no hands. Their sole function now is to be able to press on the ground with their pads so as to relieve some of the weight from under the metatarsal heads. This requires a complicated combined action of the long flexor and intrinsic muscles, for if the former contract alone the toes curl under so that only the tips of the nails touch the ground. If the intrinsic muscles are paralysed or their action is overbalanced by the more powerful long flexors, the toes will become clawed and functionless.

If there were no interphalangeal joints, i.e. if we had one bone toes, the long flexors could carry out the essential pressor action by themselves. Some races, especially Africans, seem to have begun the process already, sometimes having only one bone in their 5th toes. Lambrinudi was the first to suggest that claw toe deformities should be dealt with by arthrodising all the interphalangeal joints of the toes. Although it is a tedious procedure it is most effective in restoring good toe function.

The Personality of Tissues

Since he is dealing with function rather than disease, the orthopaedic surgeon is particularly interested in the normal working of the various components of the locomotor system. He gradually becomes aware of the fact that they all have a personality of their own. This particularly applies to joints.

The elbow and knee joints are both hinge joints in the middle of a limb. The knee, however, is a very complex structure and has to bear heavy strains, while the elbow is a simple hinge joint and the demands made on it are slight. Yet the knee takes minor injuries in its stride, it responds helpfully to good treatment, and it co-operates admirably with the surgeon. The elbow, on the other hand, can only be described as a congenital hysteric. It screams with pain at the

slightest injury and goes into prolonged spasm, and it has no use for surgeons at all.

The metacarpo-phalangeal joint of the thumb is another hysteric. After a simple sprain it takes six months to recover. Yet the same joint of the great toe is subjected to all manner of insults, surgical and otherwise and bears them with courage and co-operation.

The same applies to interphlangeal joints. Those of the fingers react, like the elbow, with a prolonged inflammatory response to any kind of trauma, which those of the toes do not.

Perhaps the most marked contrast is between fibrous tissues and muscles. The latter are extremely complex structures with a high metabolic rate and extremely arduous duties to perform, yet they hardly ever complain. Fibrous tissues, on the other hand, have little to do except be there, but they are the seat of most of the minor aches and pains that give the chemist a living. Even when muscles are blamed it is usually their fibrous components which are at fault. It would seem that like their owners, the less tissues have to do the more neurotic they are likely to be.

Bones are most co-operative tissues. They nearly always respond most helpfully to understanding treatment. Give them a job to do and they will strengthen and reorganise their internal structure accordingly, even when transplanted as a bone graft. If one explores a spinal graft some years after the operation, it will be found that it has grown to many times its original size—if the operation was successful. If, however, a graft fails to unite or is misplaced so that it has no work to do, it will disappear.

It is essential, therefore, that orthopaedic surgeons should understand all the peculiarities of the tissues they have to deal with and treat them accordingly.

Paradoxes in Orthopaedics

The orthopaedic surgeon is concerned with mending broken bones. If they are not broken he breaks them. He tries to make stiff joints move, but if they can move he fixes them. He takes great trouble to repair torn tendons. If they are intact he divides them. In this way he ensures that he is never out of a job, and can continue his paradoxical way in a paradoxical subject.

To conclude, here are a few examples to work out:—

Manipulative treatment achieves its best results in joints which move well. It is contra-indicated for really stiff ones.

After arthrodesis of the hip the patient's most encouraging comment is to say how much better it moves now.

By saying that a joint is stiff a patient means that it moves and is not stiff.

In the case of injuries to the semilunar catrilages of the knee joint the greater the joint reaction to the injury the better the prognosis.

The most important function of muscles is to prevent movement.

Muscles function in the reverse direction to that suggested by their names.

Orthopaedic surgeons make more deformities than they correct.

CORRESPONDENCE

Buchanan Reports

SIR,—I am grateful for Dr. David Davies' very informative comments in the March 18th *Guy's Hospital Gazette* regarding financial hardships in English medicine prior to the inception of National Health Service. He questions that there is evidence for *increased* financial hardships in British Medicine under the National Health Service. My answer is that the evidence for this is only indirect and that certainly my conclusion is not the only one that might be drawn from the existing data. However, most hospitals in England today are 50-100 years old; thirty years ago they were certainly not that old[1, 2]. Yet during the early years of the National Health Service essentially no money was spent for hospital construction, and during the period between 1948-1960 3.1 per cent of the total expenditure for health in England was spent for hospital construction[3]. As an illustration, this may be compared to 9.3 per cent and 6.0 per cent of the total health expenditure spent for hospital construction in Sweden and the U.S.A. respectively over the same period[4, 5]. A British Research Committee of the Institute of Hospital Administrators analyzed in detail the waiting lists of seven general hospitals in England and Wales in December 1960 and December 1961. Of the 7,445 patients in their series, 2,518, or 34 per cent had been on waiting lists for six months or more[6]. Did this same prolonged waiting exist before the inception of the National Health Service?

England spent 2.7 per cent of total health expenditure for medical research in 1962-63 as compared with 3.8 per cent in the U.S.A. in 1964[7, 8]. However, England's expenditure for medical research seems to be decreasing in recent years. It is said that annual increases in expenditure for medical research are required to pursue new developments which result from that research. England increased her rate of governmental expenditure for medical research by 16 per cent between 1960 and 1961, by 7 per cent between 1961 and 1962, and the percentage increase between 1962 and 1963 and more recent years is not available[9]. The rate of increase in U.S. governmental expenditure for medical research over the same period was 28 per cent (1960-61), 35 per cent (1961-62), and 26 per cent (1962-63)[9]. In Sweden the rate of increase in government expediture for medical research was 9.9 per cent (1960-61), 12.3 per cent (1961-62), and in 1962-63 it was 29.6 per cent.[10].

In 1965 the Ministry of Health announced that England had experienced an overall decrease (for the first time I believe) of 103 general practitioners between October 1963 and October 1964. The following year there occurred a further drop of 219 general practitioners and the net deficit over the two years produced a rise of 76 patients per G.P.[11, 12]. This emigration flux may have resulted from increased financial hardship under the National Health Service. According to one source the mean *net* annual income of the English physician is $6,500 (1965) as compared to $28,000 (1964) for the median net annual income of the U.S. non-hospital physician[13, 14]. It is well documented that over the past 12 years in England the average number of applications per vacant general practitioner has continued to decrease, and that withdrawals from general practice have continued to increase[15].

On February 1, 1965, England, largely as a governmental political manoeuvre, dropped the 28c. (two shillings) prescription fee which had been in force since 1962[16]. The number of prescriptions filled in the first seven months after February of 1965 rose by 16.7 per cent over the preceding seven months but the corresponding increase in certified sickness was only 7 per cent.[16]. In the first seven months of 1965's trial of free medicines, 23 million prescriptions more than for the comparable period in 1964, were filled, at a cost of $40,800,000 to the National Health System[17]. Ministry of Health Statistics indicate that since 1965 prescriptions have risen 20 per cent in number and 28 per cent in cost as compared to 1964[18]. Approximately two-thirds of the increased cost represented expenditures *not* proportional to increased sickness. This meant that $27,000,000 of the additional $40,800,000 spent in the first seven months trial of free medicines might not have been necessary. Is this not an increased financial hardship to British medicine? Had this $27,000,000 been spent for hospital construction during this time it

would have increased the expenditures for hospital construction for the entire nation by 28 per cent.[19].

Dr. Davies chooses to avoid advocating "any particular method of financing hospital services". Evidence from basic economics however, does, I believe, suggest a financing plan most likely to perpetuate a social medical system. For a more detailed discussion of what is perhaps the most economically sound financing basis for a successful social medical system, and a more complete discussion of the above topic please refer to—Medical Thesis, *Comparisons of English, Swedish and American Social Medical Systems,* Health Sciences Library, University of Washington Medical School, Seattle, Washington, 98105, U.S.A If this thesis is published in the near future I shall inform the *Gazette.*

Yours, etc.,

THOMAS M. BUCHANAN

3129A, Portage Bay,
PI.E. Seattle, Washington, U.S.A.

BIBLIOGRAPHY

1 Discombe, "The Organization of the National Health Service: Progress and Problems", *Lancet,* Vol. 2, November 13, 1965, pp. 1007-09.
2 Ross-Smith, "British National Health Service", *Medical Journal Australia,* Vol. 1, February 12, 1966, No. 2 supplement, pp. 13-16.
3 Ministry of Health Annual Reports, 1948-66. Calculated from total amount spent on health and total amount spent for hospital construction over the 18 year period.
4 Abel-Smith, Brian, *Health Expenditures in Seven Countries,* and The London Times Review of Industry and Technology, March, 1963.
5 Social Security Bulletin, January, 1966, Vol. 29, No. 1, pp. 5, 10-11. Calculations from amount spent publically and privately for hospital construction in 1950 and 1964 as a percentage of the total expenditure to arrive at an average.
6 Hospital Waiting Lists: Report of Study and Research Committee of Insititute of Hospital Administration, 1963.
7 Op. cit. 5, pp. 1, 5. Calculated from total private and public expenditure for medical research in 1964 and total health expenditure in 1964.
8 *The Finance of Medical Research,* Office of Health Economics, May, 1964, Data on ca. 62/63, pp. 5-12.
9 Op. cit. 8, p. 10 and Table B on p. 12.
10 *Scientific Policy in Sweden*: Organization for Economic Co-operation and Development, Paris, January, 1964, by calculation from data p. 58.
11 Annual Report of Ministry of Health, Cmnd. 2658 for 1965, July, 1966, p. 7.
12 *Medical Manpower,* Office of Health Economics, London, July, 1966, Data from Ministry of Health pp. 2, 10. 12, 16.
13 Hobson, Joan, "The Crisis in British Medicine", *Kiwanis* magazine, March, 1966, pp. 25, 26, 55.
14 Medical Economics Continuing Survey, *Medical Economics,* December 13, 1965, pp. 76-126.
15 Op. cit. 12, and Report of the Overseas Emigration Board, England.
16 Op. cit. 11, p. 13.
17 Op. cit. 2, pp. 14, 15, Calculated as 7/12 of the government estimate for the year, and Op. cit. 13, p. 55.
18 Buchanan, James, *The Inconsistencies of the National Health Service,* Institute of Economic Affairs, Ltd., London, pp. 5, 6, 16-18.
19 Calculated using L 59m for capital investment 1964/65, ref. 11.

Going, Going . . .

SIR,—May I, through your pages, point out that there are a large number of personal possessions which have been left in the box rooms of St. Christopher's and the College by former residents. We should be glad if these could be collected before 31st May, for otherwise, with the demolition of the College they will have to be disposed of.

Yours, etc.,

C. G. BAKER,
Warden

The Warden's House,
Guy's Hospital, S.E.1.

Who Seeks Him Where

SIR,—Here is a brief description of the activity of a man purporting to be a doctor at this Hospital, when committing fraud and theft.

28.7.66, at London Bridge Station approach, accosted a man and gave the name of a Student at Guy's. He stated he was a Doctor and asked for the loan of £1 0s. 0d. for petrol, promising to return the money the following day. To gain confidence he produced a stethoscope and papers with a Guy's Hospital heading. At the time of the fraud he was in possession of a motor car, Registration No. DYW 851C.

April, 1967, he entered the East Wing and accosted a student asking him for the loan of his stethoscope in order to examine a patient at the Casualty Department. He absconded with the stethoscope.

27.4.67, at Picadilly, W.1, accosted a Belgian student, stated he was a doctor at Guy's Hospital and he had left his cheque book in the East Wing. He requested the loan of money from her and was given £13 0s. 0d. After buying the student a meal he brought her back to the East Wing stating he would go to his room and get his cheque book. Needless to say, he did not return.

Seven other similar incidents have occurred at other Hospitals and students have been defrauded.

The man is known to Police but his whereabouts are not, and I am sure that he will commit many offences before he is arrested.

His description: Indian national, 5ft. 7ins., slim build, thin face, complexion coloured, black hair, aged 20/24 years, wearing heavy framed spectacles, dark suit.

Yours, etc.,

S. EVANS,
Security Officer

Guy's Hospital,
London, S.E.1.

Home Guard Washes Whiter

SIR,—Some correspondents, like Mr. Lux (*Gazette*, April 29), have an extraordinary capacity for turning wine into water—with the very greatest talent, they manage to argue their case in such a way as to effectively prove their opponent's case. But for a person who objects in his opening line to "a Personal attack" which scarcely existed, he shows little hesitation in mounting a personal attack himself. Lest anyone should be confused by some of the dubious arguments that have been put forward, I feel bound to make some reply.

I am, of course, at a considerable disadvantage in attempting to reply rationally to statements which are anything but rational. In an attempt to disguise the total lack of objective fact, we are regaled with a sticky flood of vague and emotionally charged words that have nothing whatever to do with the subject under discussion!—Long-haired, active Communists, Party funds, left-wing Socialism, imprisoned British subjects, Spain, Gibraltar, rebel body, British rule, taxpayer, ridiculed and humiliated, Tory, God knows, insane abandon, etc., etc. In fact, he's thrown in just about everything except bull-fighting, birth control and the *Torrey Canyon*.

Let us examine just a few points, taken at random from the first two instalments of the saga:

(1) "that poor, voiceless animal known as the taxpayer" is a mythical beast: We are *all* taxpayers, present or future, and Mr. Lux is not a whit more representative of us than Eliza Doolittle. If, indeed, he holds a mandate from the people of Britain, I would be fascinated to see it. If not, I do wish he would stop speaking on our behalf; for cries of "taxpayer!" make a boring leitmotif.

(2) "thousands of young British people are being denied a University place to make room for the overseas students". This is a very interesting idea—could Mr. Lux quote exact numbers and case-histories? While our methods of selection of University students are obviously imperfect, it is surely our aim to choose the best prospective students from the applicants. I know of no evidence that much

better qualified British students are ever turned down to favour inferior Foreign students. Perhaps he would care to condemn all those nasty Foreign doctors working in Britain in poor conditions, selfishly keeping the N.H.S. going.

(3) "I must admit to slight misgivings at being asked to pay more towards their education." But nobody has ever asked him to pay any more.

(4) "the taxpayer will rebel against a move to increase his taxes to avoid higher fees." Splendid stiff-upper-lip stuff, this—but then no one was going to increase his taxes, were they?

(5) As if it invalidates my account of the responsible authorities that have deplored Mr. Crosland's action, he complains that I "put the taxpayer in italics". Considering the £50 travel allowance, I don't think I could afford to. The word he refers to was in inverted commas, not italics. Must we have garbled typography in addition to muddled philosophy?

(6) "the taxpayer who foots the bill for students to express their abhorrence . . . has some say". Here comes that leitmotif again. The taxpayers footed no bill for student self-expression.

(7) "when these intellectual nitwits staged a sit-down at L.S.E., and paraded in long-haired array through many towns". These hirsute gentlemen must be incredibly versatile if they are able to sit down *and* parade through many towns.

(8) "no doubt Party funds have helped their action". I really had no idea that the C.I.A. was sponsoring the sit-downs. Evidence for these innuendoes would, I'm sure, be welcomed by the national press.

(9) "students and their teachers . . . shielded from the realities of life". In modern education, students are exposed to, concerned with, and actively engaged in the realities of life on a national and international level, on a scale unknown to students of Mr. Lux's generation.

(10) "For this is what I am, a realist, not the idealist of Mr. Simpson and his kind". Within recent years we have seen the wonderland that results from this brand of gritty pragmatism. Admittedly, many of our young people do attempt to retain some ideals in life—thank God for them. We are privileged to see in this generation, quite apart from the flamboyant and vastly over-publicised few, an international and supra-national spirit of basic unity that cuts through the taboos and prejudices that some Chauvinists wish us to inherit. We have seen the misery resulted from the bellicose nationalism, jingoism and schadenfreude of our forefathers, and would rather not see it repeated in our lives. If this is the sort of thing Mr. Lux wants to dismiss as the idealism of Mr. Simpson and his kind, then I am very proud to accept his denigration.

(11) "why should the British taxpayer have to pay for . . . seeing his country ridiculed?" It is obvious to a student of African and world affairs that whereas the Governments (often receiving many millions of pounds of British aid) may be very vociferous in ridiculing and humiliating Britain, they are still lionized by the Government. The minority of British-educated individuals are outposts of good sense and goodwill.

While I am not in the habit of regarding the *Daily Mirror* as an oracle of scientific exactitude, I would be the first to agree that Britain is living beyond her means and that Government spending overseas is excessive. Yet the financial benefit resulting from Mr. Crosland's little gesture is problematical, while many other far more urgent economies abound.

This has been an attempt to comment on some of the remarkable statements we have been presented with. Should Mr. Lux care to actually read my original letter and reply to it, I would be pleased to answer him.

Yours, etc.,

MICHAEL A. SIMPSON

East Wing,
Guy's Hospital, S.E.1.

Ah !

SIR,—That was quite some letter that your correspondent, Mr. Lux wrote in the last edition of the *Gazette*. He ranged from "Intellectual nitwits" in "Long-haired array", to Communist Party funds and students and their teachers.

He wrote of Zambia, Spain, Ghana and Sierra Leone, "these countries in Africa and elsewhere" as he described some of them, and fees of Overseas Students.

May I be allowed to express my comments on the content of his letter—BAH!

Yours, etc.,

STEPHEN ORLANS

Dental School,
Guy's Hospital, S.E.1.

At What Cost?

SIR,—We feel that Clinical Students, while on the wards, should be allowed to wear white coats.

The advantages of this habit are obvious; it would reduce the chance of cross-infection, since in suits, we walk into septic wards, then into the street, onto trains, and back into the wards. It would also do away with the habit of wearing suits, which, although very impressive, is very expensive as regarding cleaning and repairs. Finally the patients would have no difficulty in distinguishing between Students and Registrars.

The objections raised to this would include expense. To this we reply that half-length coats, akin to those worn by Dental Students, would be sufficient. As far as laundering, we are sure that no one would object to a small laundry charge, which would be negligible compared to the expense of cleaning suits.

We hope this letter will stimulate correspondence.

Yours, etc.,

R. D. SCHOLEFIELD
D. S. BRIGGS
W. R. BRANGWYN JOHN

East Wing,
Guy's Hospital, S.E.1.

In The Swim

SIR,—Within a few short weeks Guy's will take a further step forward into the future. The College and Sophie's Hostel will no longer have any permanent residents. The College is to be razed in order to build our Tower of Babel. Serious doubts are voiced amongst the cynics whether there will be enough patients for our new hospital in this rapidly depopulating area.

It is certain that the hospital will lose something invaluable by there being no senior medical students living in the hospital. The one remaining hostel stands grimly as St. Christopher's in Bermondsey. It is a crying shame there is no fixed building plan for a new hostel in the foreseeable future. Does the medical school or hospital really appreciate how expensive and difficult it is to find accommodation in London at under 70 shillings per week for a bed and roof? Do they really want students to spend nearly half their income on a bed and travelling to London Bridge? Do they really want final year medical students to live in digs in these terrible suburbs of South London we all know so well? Those establishments where an angry landlady with a cold evening meal at 6.30 p.m. awaits you inquiring why you are late. The explanations that you were checking a patient, doing the evening shift in casualty, the train was late, or the operation list was longer than expected—these never convince. You then retire to feed shillings into your gas meter to keep you warm while you try to work above the hub of the T.V. coming through the floor.

We need a hostel for senior medical students today. Over the last few years our own Student Club has been a great improvement on the old. Let us aim for

an American type of campus with a new hostel for senior students in a building containing a new theatre for the Theatre Club, a new gym and swimming pool in which students and nurses can again swim together every day of the week. Let us build a new hospital and small campus which old Guy's men will recognise as new, vital, essential and of which we could be proud.

Yours, etc.,

NOEL CURRY

East Wing,
Guy's Hospital, S.E.1.

Plastic Coil for Silver Spoon

SIR,—The opinions expressed in the letters of Messrs. Tripp, Vale and Hillier stand like beacons in the fog of confused thinking which clouds so many minds today. Passim tells us that "Sex is Here to Stay", as though its use and abuse had only just begun. That it has been a fundamental concern of social groups for thousands of years is evidenced by the variety of sanctions and taboos that have been formulated, to harness and direct its expression in a manner conducive to harmonious existence within the community. To appraise the problem in the limited context of this decade would yield a report as inaccurate as an Annelids description of a three-dimensional world.

To those of us who work in that no-man's land beyond the fringe of clinical gynaecology, where we are constantly involved with the physical, psychological, emotional and even economic sequelae of pre- and extra-marital experience, these letters would seem to merit the widest possible publicity. A high percentage of patients with these problems would claim that the preceding relationships had been considered responsible at the time. By what measure can they be sure? The responsibility would seem to be, at least in part, what they both owe to any possible products of conception. The normality of being in love on several occasions before the final choice is made is, surely not in question. By the proposed new standards, all these relationships might justly be regarded as responsible at the time. If we are to endorse this view we are asking society to accept an ever increasing number of illegitimate children, for the only certain method of birth prevention is the exhibition of the contraceptive pill and no one with any critical faculty would either prescribe or take them for long periods, until more convincing evidence is forthcoming as to their safety. Other methods are no more reliable than the individuals who use them and their reliability varies inversely with the blood alcohol levels of the partners. Mechanical and chemical devices reduce the incidence of pregnancy rather than prevent it.

Most advisory clinics keep "Failure Registers" and searching enquiries of reluctant Mothers-to-Be do not always elicit the reason why. Stories are told with monotonous regularity, of infants emerging from the birth canal, bearing a plastic coil triumphantly in their hands, or of the midwife sectioning the placenta and finding an embedded coil.

In raising this subject in so provocative a manner Passim has performed its rightful function. At no time have we been in greater need of examining its implications. Older disputants may need to move from their entrenched positions but it is those who are shortly to become the mentors of the rising generation who must see clearly along the path where they intend to lead.

Can we be certain that Hedonism is not prompting when we justify pre-marital boudoir athletics as responsible relationships? Is it not possible that fornication is being disguised with high-sounding names? Let us think and think again, in the hope that we may learn to distinguish the imitation from the genuine article, for as with objets d'art et de vertu the imitation is made for profit and the real thing for love. It seems doubtful if those who claim so confidently to know all the answers have indeed every truly comprehended life's questions.

Yours, etc.,

KATHLEEN M. LAWRENCE

2, Ripon House,
Manor Fields, S.W.15.

Prudent

SIR,—To one who deals professionally with the sexual attitudes of young women, your Passim, distinguishing between promiscuity and extra-marital commitment, was welcome and to the point. As an Anglican, however, I was sad to see included the common misconception blaming "theological dictates" alone for the prejudices of society.

The Man whom Christians profess to follow, taught that Love was above the law—and died for His pains. Alas, not only "third sex" priests but all leaders of society have nevertheless found it convenient since to "know better" than He. One could elaborate on the emotional factors which make prohibitive laws more easily acceptable than the positive challenge to love. In terms of regulating social behaviour they are perhaps merely expedient.

In the context of sexual morality, Love above the law surely implies as you do, that right and wrong are distinguished, not by the signing of an appropriate licence, but by the unselfish personal commitment of the relationship. This surely applies as much within marriage as without—yet morality *within* so-called "Christian marriage" is rarely discussed.

But not only "unbelievers" such as Bertrand Russell and Dr. Alex Comfort talk this way today. The "Quaker view of sex", Southwark's own Canon Douglas Rhymes, Cambridge's Dr. Harry Williams, and even Roman Catholics like Archbishop Roberts, seek to interpret Christian teaching on these lines. Many a humble parish priest does likewise.

Perhaps one of today's main tragedies is that the young are unable to recognise the Love of Christ behind the "Theological morality" of His churchmen. Let us not throw out the baby with the bath-water.

Yours, etc.,

PRUDENCE TUNNADINE

Grove House,
Leighton Buzzard.

Lust Safe At Last !

SIR,—It was too much to hope that your enlightened article "Sex is Here to Stay" would pass without a barrage of reactionary criticism. We are exhorted to return to the Bible, and practise a moral code based on religion, by your correspondents.

Dr. Alan Isaacs deals with the problem of God and Morality today in a recent book, "The Survival of God in the Scientific Age", "Religion has been such an effective answer to the fears associated with death, sex, and loneliness for so long, that we cannot now expect to replace it without considerable difficulty and endless experiment. But the probem has to be faced. More and more people are abandoning the idea of the supernatural." Dr. Isaacs concludes, as Passim rightly pointed out, that we need a more practical morality in this age.

Sexual promiscuity is another, and grossly exaggerated issue. In the *British Medical Journal's* original leader, out of which your article arose, the author failed to refer sufficiently accurately to one of the principal sources he quotes. This source is the *British Journal of Venereal Diseases* last December, where R. S. Morton wrote: "There seems little doubt that sexual intercourse is a more common experience for students in recent years. The data suggests that *some* of this *marginal* increase is of a promiscuous nature."

The righteous indignation of some moralists lead one to suspect that young men are sharing a bed with a different girl every night of the week. If venereal disease is a guide to the amount of promiscuity, the evidence is scant. The odds of an adolescent catching gonorrhoea are 1:1,000.

Furthermore, even though forewarned that the Devil can quote Scripture, I am not deterred in rejecting the threat contained in the third Commandment; Sir Alexander Fleming has made lust safe at last!

Yours, etc.,

D. COBELL

Out-Patient Annexe,
Guy's Hospital, S.E.1.

Any Figures?

SIR,—Regarding the recent leading article in the B.M.J., Passim, far from being censorious or attempting to moralize, is well in line with modern thinking in condoning, what is nothing more or less than, lack of sexual discipline. To-day, of course, discipline is a dirty word and no doubt the Church's insistence on it accounts in part for her present unpopularity.

The B.M.J. article suggests that society's interests are damaged as a result of changing sexual mores. Is there, in fact, any evidence to prove that they are not?

Yours, etc.,

ELIZABETH A. KING-TURNER

2, Orchard Gate,
Esher, Surrey.

[EDS: . . . *Guilty until proved innocent?*]

Five Less . . . Oh No !

SIR,—If the comments in your recent Passim on the B.M.J. article on the rise in pregnancy among unmarried female students reflects the current attitude to sex and marriage at Guy's, then I shall regretfully have to send any of my five daughters who want a hospital training to a place other than where I have hitherto been proud to have been trained myself.

Anyone who has to deal with today's social problems knows only too well the misery that comes to many children born of unmarried parents. To say that "marriage is not necessarily the only responsible relationship which can exist between a man and a woman" is to invite the breakdown of family life, on which our society is built.

The Russian Communists realised the problems they were creating with a policy of free love, in the thirties, and rejected it. Do we in Britain, as Passim suggests, believe that a "morality dependent on enlightened self-interest" is adequate "self-interest" to meet today's problems?

No, Sir! we should pay serious attention to the findings of the B.M.J. article. In the field of medicine and social reform, many men and women have been inspired by their religious belief and Christian faith. It would indeed be ironic if Svetlana, Stalin's daughter, has escaped from the God-less society which her father helped to create, to settle in the so-called free society in the West, only to find that permissiveness and sex are being allowed to replace God and absolute moral standards.

The traditions of Guy's need more than Bertrand Russell's philosophy to sustain its past achievements, and to give it a vision for society for the future.

Yours, etc.,

L. G. RICHARDS

St. Mary's Croft,
Chapel Field North,
Norwich, Norfolk.

[EDS: *Would you send any sons?*]

And So To Bed

SIR,—Guy's *Gazette*, I believe, is looked for by all Guy's people; it has a special standing: it can be likened, perhaps, to the Bell on the Forecastle Head; when it strikes the hour it gives comfort to passengers and crew.

Yours, etc.,

JOHN C. DOMINICK

Treniffle Lodge,
Lawhitton,
Nr. Launceston, Cornwall.

OBITER SCRIPTUM : To Mr. Blackburn :

Dear Sir,

Enclosed is a cutting from a newspaper, and I would like to see you as the first Doctor to make the cure.

"ANTELOPE'S MILK MAY CURE T.B. The Russians believe that people with stomach ulcers or tuberculosis can be cured quickly by drinking antelope's milk. The magazine *Ogonyok* says today that two sisters seriously ill with ulcers were given the milk in a Crimean hospital. After a month the ulcers disappeared."

Yours truly,

OLD PATIENT

SCOTOMA

Long, long after humanity could write
Men ever had one vision and one sight,
One star, one aim, one object and one good,
One essence of perfection—Womanhood.
And when the art of writing came to men,
Be it with quill or stylus or with pen,
Their verses flowed in stanza, ode and sonnet
To beauty shrouded in an Easter bonnet;
Or, gallantly, they'd praise in many a line
Th'aesthetic beauty of the form divine,
Or spend long hours composing lengthy hymns
Extolling shapeliness of face and limbs;
While others, looking deeper at their goal,
Extolled the beauty of the heart and soul.
No words were great enough to laud her name
Until, one day, a war with Russia came;
And men fought men, and dysentery and fear
And died in thousands in the cold Crimea.
One woman, taking pity on the male,...
Succoured the wounded—Florence Nightingale.

The years sped by, and Florence's young minions
increased and multiplied in the dominions.
Authority, ere seeking for a norm,
Put the fair damsels into uniform:
A frock of drab, and apron and a hat—
"We must disguise their sex—we can't have that."
Voluminous, ill-fitting, baggy, lest
A dying man should gaze upon a breast;
No one with wounds or with diseases laden
Must KNOW that he is tended by a maiden.
A sexless drone, berobed in one great sack
So no man knew which was her front—or back.

Is it surprising, then, that in our clinics
We should produce a race of heartless cynics?
Familiarity contempt has bred,
And when we find her standing by a bed
We see her—yes—but only see the half—
Ignore the girl; she's just the "Nursing Staff";
Or if some petty whim of ours is missed
To rant and rage we often don't resist,
And speak both to humiliate and blister;
We do not see the woman—just the Sister,
Or, finding fault, with wounded pride, we curse—
Why can't we see the girl—not just the Nurse?

B.D.J.

OBITER DICTUM

Mr. T*mkinson, turning to his Dressers after a Manchester Repair: "Love will find a way."

REVIEWS

HUMAN RELATIONSHIPS IN OLD AGE.

T. N. Rudd, M.D., F.R.C.P. Faber and Faber, 1967. pp. 140. 16s.

This book, by an experienced geriatric physician, is really a series of essays. The connecting theme is a discussion on interpersonal relationships engendered by the presence of elderly infirm and sick people in the community. Without involving the reader in very technical or detailed psychopathology, the author attempts to bridge the gap between those who deal with and care for old people and the elderly person in a modern setting. His remarks are addressed not only to doctors, but to social workers, Welfare visitors, and indeed through them to the family itself. Attitudes of various parties to one another are discussed somewhat philosophically with passing reference to psychological reactions, religion and also a good deal of practical common sense. The most useful part of the book to doctors and nurses deals with the cntribution made by hospital treatment to the betterment of the life of the disabled elderly, whether in a rehabilitation setting or in a long-stay ward. The anticipation that admission to residential homes should be more under medical control than that of the Welfare department may be controversial but prophetic. A useful book to ponder.

---

50 Years Ago

Something Old—Something New?

May 19th, 1917.

"There are now a considerable number of students back at the Hospital who have been away on service in various combatant units. Those who have been allowed to relinquish their commissions to take up their medical work work again are entitled to a gratuity on discharge. We believe that in some cases this has not been obtained. If a first application to the War Office does not produce any satisfactory result, payment of what is due may sometimes be obtained by continued and importunate demands."

90 Years Ago

A Freudian Gratification

1877.

"The Chinese Ambassador, accompanied by his secretary and interpreter, visited the hospital on Friday, June 16th, and was shown over the hospital by the Treasurer, Dr. Pavy, and Mr. Steele. He was much amused by the benzoline cautery, and was not satisfied that it was not until he had burnt his fingers. He also took great in the electrifying room, which has recently been furnished with a great many new instruments. Here he took 'a shock', and then proceeded to inspect the museum and new building. In taking leave, he expressed himself highly gratified with the visit."

On Medical Education

May, 1877.

"The great aim then of the age appears to be the teaching of knowledge to an individual which will be utterly useless to him in his ordinary life, and we may, therefore, take heart when *wise* authority decrees that a consummate knowledge of the anatomy of an earthworm is of the utmost importance to a scientific physician."

THE NURSES' LEAGUE

Guy's Hospital Nurses' League was founded in 1900 and is one of the oldest Nurses' Leagues in existence. In this article I will try to present a general picture, amplifying the three objects of the League. Details are in the Constitution which has recently been revised.

(1) To promote social and professional interests between past and present nurses. This is really the most important object of the League, for without it there would be no way by which the family of nearly four thousand Guy's nurses could keep in touch with each other and with the Hospital. The journal published annually contains news of members far and near and of events within the Hospital. The annual reunion and the biennial cocktail party provide the opportunity for meeting; and what lively meetings the are!

(2) To provide for present nurses, increased facilities for recreation. This is done chiefly through the sections of the League, i.e. Swimming, Tennis, Music, Library. Student nurses are associate members and the Council welcomes requests for amenities from their representatives of the Sections; for example, requests for television sets, a washing machine, equipment for tennis and swimming have been granted. Recently the Council decided to supply copies of the *Gazette* to the various Nurses' Homes. In the fifth edition of the League Handbook, 1909, one reads under "Cycling Club", that club machines may be engaged for a nominal charge of 1d. for three hours. Special machines were kept for learners and members were not allowed to use other machines until they had received a certificate from the Captain. This was in the days when the League possessed a cottage with a garden and tennis courts at Honor Oak Park. The cottage steadily lost its appeal and after the War the Council decided to sell it.

(3) To provide a register of those who have received their certificate of General Training at Guy's Hospital or the three years' training at the Evelina Children's Hospital and who remain members of the Nurses' League.

Since the inauguration of the journal, the register is brought up to date annually. It is of great value to members, particularly when posting Christmas cards.

Some years ago, a few nurses not trained at Guy's but who had given considerable service to the Hospital, expressed the wish to join the League. In 1960 the Council agreed to admit nurses who had given a minimum of three years' service to the Hospital. We are pleased to include in our membership a small number of Honorary members who are or who have been connected with the Hospital. From time to time, they may serve on the Council, bringing a different viewpoint to the discussions.

The happiest relationship has always existed between the Governors of the Hospital and the League. Very generously we are given accommodation for our work and our play. The expert advice and practical help given in financial matters are invaluable. The League has been pleased to present gifts to the Hospital such as the carved crest in the Court Room, the plaque of Thomas Guy in the entrance to New Guy's House, and various furnishings in the Chapel. The League has two additional assets of great benefit to members and indirectly to the Hospital. The scholarship fund, in memory of Sir Cosmo and Lady Bonsor, has been raised solely by members of the League. The present annual award is £200, to be used for post-registration study.

The Benevolent Fund exists to help members of the League in need of financial help. It is used chiefly for elderly members who may be in poor health or living on small pensions. Consideration may be given to the claims of student nurses. In 1966, over £400 was donated. The names of the recipients are confidential to the Honorary Officers.

Like the Hospital, the Nurses' League has a great tradition. We must ensure that its future is equally successful. Each reunion demonstrates its great capacity for the spirit of Guy's which is not confined to the precincts of the Hospital but must be alive wherever Guy's nurses are to be found.

FLORENCE TAYLOR,
Chairman, Guy's Hospital Nurses' League.

NURSING SECTION

The Borrowers

Generations of nurses have fed housemen in the ward kitchen. Generations of night sisters have studiously avoided noticing the steam rising from the desk drawer into which a cup of coffee has been incontenently thrust at their approach. Nurses have also traditionally finished the patients' pudding behind the kitchen door: indeed, one unfortunate was enshrined for ever in the literature when she shared not only the patient's pie, but also the resultant food poisoning.

The pattern is changing

No hospital grudges cups of milk to housemen or pieces of pie to nurses, but the pattern seems to be changing; imperceptibly the piece of pie has tended to become a full breakfast, cooked and eaten in the kitchen by the ward nurse who lives out. The borrowed hand towel ("to keep my embroidery clean") has become a set of sheets for the flat with free laundry thrown in. The aspirin for a headache has become a handful of antibiotic tablets or vials of penicillin and a syringe.

The old pattern of care of hospital property has changed, too. Decentralization, so sensible and so inevitable, has brought with it depersonalization. Say the words "lost teaspoon" to any nurse over the age of 40 and you will elicit as a reflex response a story about sieving the contents of the pig bucket in search of lost cutlery. Those were the days when sisters used to recognise their ward sheets as old friends; every stain, every mark was familiar. No one would wish those days to return, but has the pendulum swung too far the other way?

Multiply by 600

Now that we live in an age of disposables, how easy it is to believe that everything disposable is free. Those who "borrow" equipment rarely think of this in terms of simple multiplication. How easy when one has run out of soap and the shops are shut to take a tablet from the plentiful ward stocks, how different this looks when multiplied by 600. Central Sterile Supply Departments lose hundreds of pairs of scissors a year, sometimes they even run out of scissors while the patient is waiting to have his sutures removed, but no one ever seems to connect this with the handles sticking up out of *her* pocket.

The Dividing Line

Where is the line which divides borrowing from stealing? Of course, real thieves come into hospitals and steal everything from the candlesticks in the Chapel to the clocks on the wall, but when borrowing starts affecting the patients' supplies, then it is surely in danger of becoming stealing. What can a hospital do? As regards real stealing, very little, short of Gestapo methods which would be impossible to enforce. But what about borrowing—is it inevitable?

Perhaps there are three possible lines of action. First, all obvious cases of waste should be investigated. It is hard, when one has virtuously refrained from eating a piece of bread, to see whole loaves thrown away. Secondly, if it is possible to obtain these things from a legitimate source, the illegitimate source will dry up. In the past, as junior nurses, we used to steal milk from the wards till it was provided for us in the nurses' home.

Lastly, the onus rests on each individual. Each one of use who works in a hospital should re-examine the curious dual standard of morality we have acquired during the time we have spent in it. Every individual must pause with the box of Kleenex, the cake of soap or the sheet in his or her hand and do a little instant multiplication. Multiply by 600 or so and think again. Rehearse all the arguments . . . the Health Service isn't it? . . . It won't make any difference just this once . . . But *I* need it . . . There is plenty left for the patients. And then put it back.

"Beat the Q.M."

In the Services, elaborate precautions are taken to reduce "borrowing" by making people officially responsible for equipment. This, apart from producing hoary jokes about the reason for the captain going down with his ship, has produced a pleasant element of Gamesmanship into Service life. Beat the Q.M. has become a well-accepted part of ward management; as he leaves the ward by the front door following his inspection, a file of orderlies leaves by the back door to return the borrowed equipment.

Surely the Health Service is not going to become like this—a place where breaking rules and regulations becomes an end in itself? The answer depends on each one of us and our own estimate of the fine line dividing borrowing from stealing.

(*Reprinted by courtesy of the Nursing Times*)

CANDIDA

STAFF CHANGES AND APPOINTMENTS

CHANGES

C/N G. Cawthorn, promoted to Night Sister Medical Wards.
C/N I. Cleghorn, promoted to Night Sister Nuffield House

NEW APPOINTMENTS

S/M E. J. Evans, S.R.N., S.C.M (Radcliffe Infirmary, Oxford), to Victoria Ward.
S/N J. Van Ryssen, S.R.N. (St. Mary's, Paddington), to Intermittent Dialysis Unit.
S/N A. Wood, S.R.N. (University College Hospital), to Surgical X-Ray.

DEPARTURES

C/N S. J. Montgomery, from Job Ward.
S/N P. Carnall, from John Ward.
S/N I. Corner, from Casualty.
S/N K. Green, from Cornelius Ward.
S/N J. Harebottle, from Nuffield D Floor.
S/N M. Herbstreit, from Patience Ward.
S/N E. A. Hobbs, from Nurses Sick Room.
S/N J. Homan, from Surgical X-Ray.
S/N D. J. MacAuley, from Ruth Ward.
S/N R. T. Mirfin, from York Clinic.
S/N P. Tomlinson, from Astley Cooper Ward.
S/N B. A. Witting, from Out-patients Department.

SPORT

LADIES' SQUASH

A new Squash League was formed last season for colleges of the University of London. For its experimental form there were just three members in a team—a reflection of the difficulty in raising a team.

Initially ten teams were enlisted but several of them scratched. However, Guy's miraculously was awarded a victory in the League on points.

SWIMMING

In the Great Britain Amateur Swimming Championships at Crystal Palace, Rod Jones took first place in both 110 yds. and 220 yds. backstroke.

RUGBY

At the Annual General Meeting, Mr. Batchelor, the President, commented upon the success of the Club this season. Only twice before, in the 1920-21 and 1921-22 seasons, has Guy's scored over five hundred points. Mr. Batchelor expressed his delight at the Club regaining a fixture with Wasps for the 1967-68 season. C. Thorburn, the Captain, was not quite so elated and spoke of his disappointment that the side had lost the last five games.

Dr. Hugh Burry, with the "go-ahead" look, talked of the need for more trials and for the establishment of a 3rd XV as a competent Colts side for potential 1st and 2nd XV inclusion.

The following officers were elected for the 1967-68 season:—

President: J. S. Batchelor, F.R.C.S.
Captain: C. W. Thorburn.
Hon. Secretary: D. Elliott.
Hon. Assistant Secretary: J. F. Price.
Hon. Secretary, Junior XV: C. Rowland.
Hon. Secretary, Schools XV: R. Prudo-Chlebosz.
Hon. Match Secretary: G. M. Preston, M.B., B.S.

CRICKET

The Cricket Club began their season by playing Beckenham on April 29th and Horsham on April 30th—both games were drawn. Guy's were somewhat lucky with their result against Horsham but were unfortunate not to score a win over Beckenham.

Only Clark and Chase showed promise for the season by scoring 56 and 48 respectively against Beckenham.

The Club's game against R.N.V.R. was abandoned as their opponents could not raise a side.

The games against Putney Eccentrics and London Hospital were cancelled by bad weather.

DIARY

CRICKET

May 13.—Honor Oak. Home. 2.30 p.m.
May 14.—Ashstead. Away. 2.30 p.m.
May 17.—Stoics. Home. 2.30 p.m.
May 20.—Strollers. Home. 2.30 p.m.
May 21.—Reigate Pilgrims. Away. 11.30 p.m.
May 27.—Dragon Flies. Away. 11.30 p.m.

ATHLETICS—UNIVERSITY OF LONDON CHAMPIONSHIPS

1st, Guy's, 81 points
2nd, University College, 62 points
3rd, Imperial College, 57 points

For the third year running Guy's maintained their supremacy in this event—the very convincing margin of victory being one of the largest, if not the largest, in the history of the competition.

The Guy's team consisted of ten athletes who, between them, were entered in the full eighteen events that such a championship encompasses. Only four "firsts" were attained, but there were few events in which there were not one or two Guy's athletes in the placings.

On the Friday night Guy's gained early points in the 220 yds. Hurdles when Morgan, superbly fit and relaxed, won the event, P. Bundered gaining third place. Osborne retained the discus title but his winning throw was some ten feet below his best. The veteran Edwards gained the first of his many points with a fourth place.

On Saturday afternoon Edwards, with able support from R. Bailey, enabled Guy's to gain seven points from the hammer. Having completed this event, Edwards presented himself at the javelin event (four points) and finally at the pole vault.

Osborne provided further points, together with Bailey in the shot, and with an inspired throw gained a further placing in the javelin.

Inauspiciously the points accumulated, and after twelve events Guy's had a lead of nineteen points. On the track, Nwator, after a fine run in the heats, was unfortunate in pulling a hamstring and gained fourth place in the 100 yds. Domaingue and Bates gained placings in the 120 yds hurdles, the former gaining the title. Our supremacy in the hurdles events was further emphasised when Morgan, apparently effortless, won the 440 yds. hurdles by thirty yards. With further training and some more practice over the hurdles, the Student Games in Tokyo are well within his grasp.

J. Price, in his first season at Guy's, ran well against good opposition, and his time of 23.7 secs. for the 220 augurs well for the future. In the 880 yds. Choat, with great determination and a stirring finish, was just unable to catch his opponent, but his time in his first competitive race of the season was very encouraging.

In the final event of the afternoon Morgan again displayed his ability and fitness with a second placing in the 440 yds. flat. Mention should be made here of Miss Dow who won both the women's 100 yds, and long-jump—the nucleus of a woman's athletic team at Guy's perhaps. Congratulations to her on her achievements.

The athletic team at Guy's can regard itself as very fortunate in that it is imbued with a spirit of "have a go at anything"—a policy which has, and will continue to attain, many well deserved successes.

Results

J. Domaingue—1st 120 yds. Hurdles; 4th Long-Jump.
D. Osborne—1st Discus, 124ft.; 4th Shot; 5th Javelin.
I. Morgan—1st 440 yds. Hurdles, 54.6; 1st 220 yds. Hurdles, 25.7; 2nd 440 yds. 50.2.
G. Edwards—2nd Hammer; 3rd Javelin, 154ft.; 4th Discus; 4th Pole-Vault.
D. Choat—2nd 880 yds., 1.59.1.
M. Bates—4th Triple-Jump, 42ft. 2½ins.; 6th 440 yds. Hurdles; 6th 120 yds. Hurdles.
R. Bailey—5th Hammer; 5th Shot.
P. Bundered—3rd 220 yds. Hurdles.
F. Nwator—4th 100 yds.
J. Price—4th 220 yds., 23.7.
Miss R. Dow—1st 100 yds.; 1st Long-Jump.

D.A.G.B

CRICKET REPORTS

GUY'S v. BECKENHAM

At H.O.P. Saturday, April 29th, 1967
Result: Drawn

Guy's opened the new season by having the better of a dull draw with a moderate Beckenham side. The Guy's team included two Freshers in D. Crafts and Watt-Smith, and a new wicket-keeper in Bowden.

Having won the toss and elected to bat, Guy's made a disastrous start, losing 3 wickets for 25. Clark and Chase both proceeded to bat responsibly and well, and gradually wore down the opening attack, who received considerable assistance from the unpredictable wicket. Soon after Clark had reached a most meritorious 50, he was out trying to force the pace; he and Chase had added 76 invaluable runs. Appleby and Crafts J. soon followed, leaving Chase and D. Crafts to add some quick runs before Chase was out for 48.

Beckenham made a cautious start before D. Crafts, making the ball lift off a length, made inroads into their early batting. He captured the first 4 wickets.

Unfortunately, the other members of the attack were not so penetrative, though J. Crafts and Pearson had accurate spells. In spite of the help of some poor running by the opposition batsmen, Guy's could only claim 8 wickets, enabling Beckenham to force a draw.

Guy's: 137—7 dec. (Clark 56, Chase 48).
Beckenham: 104—8 (D. Crafts 4—38).

M. I. APPLEBY

GUY'S v. HORSHAM

Away. Sunday, April 30th, 1967
Result: Drawn

On a warm afternoon, Horsham took first use of a lovely batting wicket. They proved to be a powerful batting side, and in particular their opening bat took full advantage of the conditions to make a chanceless 136 not out at a run-a-minute. Mainly as a result of his efforts, they were able to declare with the formidable total of 205—4. Throughout this onslaught, the Guy's ground fielding was consistently good, though the throwing was rather erratic. Beacham, who finished with 3 of the wickets, and Pearson, were the pick of the bowlers.

In their turn, Guy's produced a poor batting performance; there was really no excuse for not making more runs than were mustered—most of the side contrived to get themselves out. Once again, a poor start had to be retrieved by the middle-order batting; Appleby made a brisk 37, Thomson defended stoutly for his 25, and D. Craft batted well to make 30 not out.

The last over saw Pearson demonstrating, to the undisguised relief of our good-looking number eleven, his immaculate forward defensive—the more orthodox of the two strokes in his repertoire! So in the end, Guy's thankfully held on to draw a game which they should never have been in danger of losing.

Horsham: 205—4 dec. (Sadler 136*, Bowles 40, Beacham 3—37).
Guy's: 122—8 (Appleby 37, D. Crafts 30*, A. Thomson 25).

M. I. APPLEBY

HOSPITAL INFORMATION

PASS LISTS

EXAMINING BOARD IN ENGLAND
Final Examination, L.R.C.P., M.R.C.S.

Medicine

N. M. Bannerman
K. G. E. Brown
R. C. Bucknall
E. P. Davis
P. D. M. Ellis
A. P. Freeland
B. D. W. Harrison
R. A. C. Hughes
R. P. Juniper*
P. J. Leopard
M. J. Lockwood
B. W. R. Moore
E. A. O. Orebiyi
J. G. Pickering
K. H. Riding
R. C. G. Rowe
H. G. Sharp
D. Stratton
J. H. Topham*
N. M. White
J. L. Williams
J. W. Wright

Midwifery

P. L. Amlot*
J. T. H. Anderson
P. W. Briggs
K. G. E. Brown
E. P. Davis
P. D. M. Ellis
R. P. D. Hancock
B. D. W. Harrison
A. B. Loach
J. N. MacLean
R. F. J. Matthews
B. W. R. Moore
J. H. Newman
D. J. Peters
J. G. Pickering
E. N. Turfitt
J. M. Worms

Pathology

J. K. Bell
G. D. Budhall
J. R. K. Butchey
R. S. Carruthers
W. R. Dunham
B. W. Eliot*
A. J. Hamilton
N. Irish
P. J. Leopard
J. N. MacLean
D. J. Osborne
J. L. Williams
R. H. Williams
J. M. Worms
J. W. Wright

Surgery

J. T. H. Anderson
J. A. Crawshaw*
S. C. A. H. Davoodbhoy*
Christine Garrett*
E. N. Gubbay*
R. P. D. Hancock
I. P. Hine*
R. H. S. Lane*
T. C. Leung
A. B. Loach
J. H. Newman
Janet Ockleshaw*
W. P. J. C. Onyeama*
A. A. Osborne*
D. J. Peters
A. J. M. Proctor*
J. H. Williams*
P. M. Wood*

UNIVERSITY OF LONDON

Special Second Examination for Medical Degrees

D. N. Anderson
D. Armstrong
D. G. Aspin
J. L. Bates
I. R. Battye*
R. G. A. Behrman
A. A. Bell
D. Bellamy
Janet Mary Birtwhistle
M. D. Boll
P. E Bundred
A. J. Camm
R. D. G. Carmichael
A. J. Caro
K. K. Chan
C. J. C. Cox
Suzanne Daddy
D. L. Davies
M. E. Denyer
N. J. Dodd
T. Dutta
D. R. Elliott
P. J. D. Evans
W. H. Franklin
J. A. A. Govan
G. E. Gower*
R. A. Gude
R. D. Hartley
M. J. Hawkins
M. M. Henry
G. B. Hey
T. W. Higenbottam
A. P. Hill
M. Horrocks
K. M. Howard
A. Hutchinson
T. M. Jack
W. R. B. John
D. A. Jones
B R. Kennings
M. A. Knight
J. W. S. Kraemer
M. A. La'ajam
Vivien Ann Leask
R. A. Lomax
C. A. McCarthy
R. P. Mandeville
R. Manna
D. N. Morton
E. Neville
J. H. Pitt-Payne
J. A. R. Pook
R. R. Z. Prudo-Chlebosz
J. N. Rosenberg
R. H. Savage
M. F. Shiu
W. H. Smith
P. J. Steer
Deborah Jane Stephenson
M. K. Tan
M. A. Thompson
Anna-Maria Tihanyi
P. C. Toone
T. Treasure
R. S. Trompeter
G. C. Voss
R. J. Wainwright
Angela Margaret Walker
D. E. Ward
A. C. White
H. J. H. Williams
C. R. J. Woodhouse
M. E. Worby
R. G. Wright
Heather Jane Margaret Wynburne

UNIVERSITY OF OXFORD

2nd B.M. Examination
Pharmacology and Principles of Therapeutics
R. A. Oxlade

Special and Clinical Pathology
M. Sutton
C. W. Thorburn

CONJOINT BOARD

D.I.H.
W. F. Dummer

D.C.H.
H. A. Armstrong
A. G. Boohene
J. C. Robertson
C. H. Smith

**Have completed the Examination*

PERSONAL

DULWICH, LONDON—Guy's man requires Dental Assistant. Complete clinical freedom and generous remuneration. To start July. Apply Box No. 13/5.

LONDON, W.1.—An assistant Dental Surgeon is sought for an all-Guy's three-man practice; mainly conservative N.H.S. treatment permits sensible working hours. No Saturdays. Bachelor preferred. Telephone: WELbeck 9433.

CHANGE OF ADDRESS

Dr Mary Restell, Upper Flat, Dormy, Whitwell Road, Ventnor, Isle of Wight.

Dr. Elizabeth Wilkinson, St. Gerardines, Lossiemouth, Moray, Scotland.

BIRTHS

ALLDAY—On April 23rd, 1967, at Boston, Lincs., to Philippa (née Haynes) and Richard Allday, a seventh child, Simon Benedict.

BOGER—On April 22nd, 1967, to John and Benita, at St. Luke's Hospital, Darlinghurst, Sydney, N.S.W., a daughter, Christina Diane.

DEATHS

FOX—On April 20th, 1967, at his home, Staveley, Bishop's Teignton, Devon, Walter Egbert Fox, M.B.B.S. (London), D.P.H., aged 81.

ROSE—On April 27th, 1967, at home, after a long illness, Jack Peter Ignatius Rose, M.R.C.S., L.R.C.P., L.D.S.R.C.S.Eng., dearly loved husband of Evelyn and father of Alastair and Sulia

We would like to remind our readers that all copy for inclusion in the Gazette must be received eight days before the publication date.

Personal notices one shilling per word (Minimum £1. 1s. 0d.)
Birth, Marriage, Death and Change of Address notices are without charge to subscribers.
Non-subscribers will pay £1. 1s. 0d. for all notices other than Personal.

GUY'S HOSPITAL GAZETTE

EDITORS D. S. ROBINS and C. B. BROWN
SPORTS CORRESPONDENT J. G. PAYNE
NURSING CORRESPONDENT E. A. MALPAS

FORTNIGHTLY TWO SHILLINGS VOLUME 81 NUMBER 2057

The opinions expressed in these columns are solely those of their authors and are not to be taken as the views of the Hospital as a whole.

PASSIM

Residents and Local G.P.s

For almost too long the cry has come from divers quarters for closer contact between those who learn and practise their medicine in hospital and the general practitioners. The subject of General Practice has yet to find a place in the curriculum of virtually every medical school in this country, in spite of the fact that a high proportion of the products of the schools are to spend their professional career in that sphere. At Guy's it is true that a *voluntary* programme exists for final year students to spend a short stay with a general practitioner but still surprisingly few of these students avail themselves of this opportunity. The programme for attaching students to the Thameshead scheme is still quite some way in the future.

Instead of those responsible for education taking the student more actively into the realm of the G.P. we find a relatively concentrated effort in bringing the G.P. into the realm of hospital medicine, as evidenced by growing numbers of refresher courses being offered at Guy's. The presence of these we applaud: it is the imbalance that has yet to be redressed satisfactorily. It was, however, with some pleasure that we noted the initiative of the present Residents in bringing about joint clinical meetings with local G.P.'s, the first on Wednesday last. It is such contact that may help to avoid the linking tendency on the part of those who have come to work out their pre-registration days to consider themselves the medical superiors of the G.P.s with whom they come into indirect contact. The opportunities to exchange ideas on the administrative problems common to both, to take the Emergency Bed Service as but one, can be further rewarding. We wish the venture success, recommend its adoption in "other places" and trust that the efforts of those who are still in the early stages of their medical learning will be noted by those who purport to give a *full* education to the future doctors of this country.

Place for Prejudice?

Recently a letter from a group of gynaecologists was printed in newspapers throughout the country. It makes two unfounded allegations about the Medical Termination of Pregnancy Bill.

The first is that the Bill means "ante-natal euthanasia . . . not for medical, but for social reasons"; and the second that the "manipulators" of the Bill have widened its provisions.

The Bill simply codifies the existing practices of many gynaecologists throughout the country; and the insistence on the exclusion of all social factors as grounds for abortion would drastically cut down the number of legal abortions which take place at the present time.

The distinction between medical and social factors in the treatment of a patient for whatever complaint would be contrary to the very best traditions of British clinical practice. One wonders what sort of medicine these gentlemen in fact practice.

With respect to the second allegation, the Bill, in fact, includes three important new safeguards. First, any termination will have to be sanctioned by two doctors, instead of one; secondly, all premises where abortions can be carried out will have to be specially registered and approved by the Ministry of Health; thirdly, every abortion must be notified to the Ministry.

The opponents to the Bill would be better off suggesting intelligent methods to overcome the problem of 100,000 illegal abortions per year than casting spurious doubts about the intentions of the proponents of the Bill and creating a mythical fear of multitudinous abortions "on the house".

They could well consider their prejudices in their apparent attitude that if a girl falls pregnant out of wedlock she must suffer the consequences. In short, she must pay for her dalliance.

Ceremonial Plans

The long, chequered history of that notable though not exactly noteworthy edifice known to generations of Guy's men and women, for one reason or another, as the College, is in its last days. This we have on good authority. Unless, in some equally dark and unfriendly tomb a sinister plot is being conceived to give it yet another lease of dubious life, its demolition is a matter of weeks away. The event, even more than the destruction of the Park currently in progress, will be yet one more piece of evidence in establishing the theory that the construction of the new Guy's is at last off the ground. Another authority, with a dark halo of experience tells us, however, that actually the building contractors (sic) have simply run out of ground in which to dig holes, and a witless wit merely murmurs that this is really the psychedelic way of building new hospitals perfected by the Ministry of Health.

To forestall these and similar suggestions the *Gazette* has considered it its duty to ensure that the sledge-hammers begin on time and do not stop. An all-out, or in for that matter, campaign must

be launched. Peak viewing time adverts, a word or two to Radio Caroline *et ilk*, a blaze of Elstree fantasy between the doric columns on the cinema screen, even, dare we say it, letters to *The Times* and the Bishops of Southwark and Woolwich, not forgetting the *piéce de resistance* of corresponding with M.P.s' secretaries. The land must reverberate with each tumbling brick so that the very momentum of sound may forestall any attempt to halt the process once it has begun.

But to put action into words we have an additional idea for the authorities to use. Let Mappin and Webb be commissioned to fashion a silver and platinum sledge-hammer and then issue an invitation to a select group of former College residents to attend the Day of the Last Final Blow. If the Art Society will produce a flourish of suitable posters, the *Gazette* may even produce a limited edition of Little Brown Books. The participants in this Action Revolution can assemble in the car park, outside the Miller, and in the Trench and begin the three-pronged march on the College. There the Sledge-hammer will be handed to each in turn by the M.C.—sheer diplomacy demands we leave the choice of this post to higher debates. Competition to be invited to have a swing, what with the sheer ecstasy that the action will provide, will be intense. Finally, once the Tower Block has risen from the shadows of the drawing boards, the ceremonial sledge-hammer could be incorporated into a monument, on shall we say a Hepworth pedestal, and thereby do as much for the new building as Guy's statue does for the older part of the hospital.

For those who fail to be invited or who are unable to be present we offer a vicarious consolation opportunity of joining in. We intend to publish a Commemorative Issue, and would welcome reminiscences of any kind, in words, drawings or photographs. Also a prize of three guineas is offered to the best folk song without music to reach the *Gazette* office by June 10th, and if the Students' Club respond as they ought to by arranging the next Inflam in the old Upper Spit, it could be recited at the end of the evening by whichever beat group is employed. We are, believe it or not, being serious, so please hurry and let us have contributions soon, for there is a strong rumour that the *Gazette* Office may be besieged by a small but powerful group who are in their unfortunate way key members of the Protection of the Postmature College Association—if it hasn't formed yet then it is bound to.

To the pen, men of Guy's!

Common Market and Medicine

For the people who favour entry to the Common Market, the main point is political; it would constitute a definite break with 200 years of British history, an acceptance that we are no longer a major power with special police duties in the Far East and Africa, and an appreciation that our future depends on our own competitive skills as a European power.

The anti-market arguments, when they are stripped of their foreign prejudices, are likewise political, and fall into two main groups: that of the extreme Left, who see the Common Market as a link-up of capitalist powers based on the idea that competition is the best way of raising productivity and that any further strengthening of the E.E.C. will increase Europe's east-west split. Secondly, that of the Right-wing who still have deep attachments to the Commonwealth and the United States and who condemn the Common Market as being inward-looking and undemocratic in its institutions.

But what woud be the consequence of the Treaty of Rome for the medical profession? Article 3 calls for "the abolition, as between member states, of obstacles to the free movement of persons, services, and capital"; Article 52 requires that "restrictions on the freedom of establishment of nationals of a Member State shall be progressively abolished" and Article 57 makes it clear that freedom of establishment means the "mutual recognition of diplomas, certificates, and other qualifications."

Many fear that the harmonization of educational and practical requirements for general practice and the specialities will result in a move towards the lowest common denominator, that Great Britain might be the principal sufferer therefrom and that in some way the public will have to be safeguarded against any possible ill-effect on its medical services. On the other hand, in a country where the State is virtually a monopoly employer and where, by tradition, the professional status and responsibility derive much more from appointment to a specific vacancy than from possession of a particular qualification, the profession hopes it would be able to insulate itself both in general and hospital practice from any major change. But there is the provision of Article 3 which can be invoked to over-ride any provisions that run contrary to it, and that the laws or regulations of a member nation may have to be amended if in theory or in practice they prevent the free movement which the Article enjoins.

The pre-occupation with our standards, our traditions and our achievements appear to have blunted our critical abilities and to have led us to a myopic view of the Treaty, overlooking the aspirations which gave it birth and the changes in attitudes which it reflects, and ignoring the evolution of new concepts within which these standards may shortly have to be viewed.

Perhaps the most alarming feature of all those hostile to the Common Market is that there would be changes. It was partly the fear and unwillingness to change which has gripped this country for so long that resulted in the "Non", last time we applied.

To paraphrase John F. Kennedy's dictum, "Ask not what the Common Market can do for you, but what you can do for the Common Market".

Quizette

We publish in this issue the first of a series of multiple choice questions on a variety of subjects, compiled in the main by registrars

and lecturers on the staff of the Hospital or School. It is our hope that these will be not only of interest and an opportunity to test knowledge and/or intuition, but also a stimulus to further reading. To this end the contributors have taken care to give rather fuller answers than are usually offered with such quizzes and in addition have included relevant references. Correspondence is invited.

Dr. GEORGE HAYES. PLYMOUTH.

The death of a colleague is always sad, but when it is one's former house physician, personal friend and family doctor, the loss seems even greater.

George, a Guy's man like myself, died at the early age of 47, on 29th April, 1967. After qualifying in 1944, he did a number of house appointments at the West Middlesex, Farnborough and Joyce Green Hospitals. He then decided to work in the West Country and was a house surgeon at Freedom Fields Hospital and a house physician at the Scott Hospital in the same town.

By this time he had become a very experienced doctor and decided to enter general practice with an old friend of mine, becoming a full partner just before the start of the National Health Service.

From then on he devoted his life to the welfare of his many patients, taking a great interest in many outside organisations such as the St. John's Ambulance Brigade, of which he was the Divisional Surgeon. In recognition of his services to the Brigade he was appointed as Serving Brother in December 1965. He was also Deputy Police Surgeon and a keen member of the B.M.A. who appointed him as the Hon. Press Secretary of the Plymouth Division.

He was a great favourite with all his patients, for not only was he a tireless physician, but he had the gift of inspiring confidence and affection in all those he attended during their illness, giving them of his best at all times and never sparing himself night or day.

For nearly a year George knew that he was suffering from an incurable disease, yet in spite of many painful investigations and operations, his courage never failed, and he will always be remembered for his cheerful fortitude by all those who were associated with him during his last months.

A splendid doctor and a sincere Freemason, who was a Past Master of his Lodge, he will be sorely missed by his fellow practitioners and grateful patients, many of whom were doctors.

Sincere sympathy is extended to his wife June, his mother, son and daughter, all of whom sustained him during his many months of suffering.

D. F. J.

GUY'S DIARY

MAY			EXHIBITION: In the Gordon Museum. "Catheterization."
30th	Tu.	5.00	Medical Genetics Series: Physiology Theatre. Mr. J. L. HAMERTON. "Chromosomal Genetics I."
		8.00	Music Circle: East Wing. Mr. NIGEL WINTER. "Gilbert and Sullivan."
JUNE			
5th	M.	1.00	Clinical Lecture. Mr. BEARD.
6th	Tu.	1.00	Clinical Lecture. Dr. WAYTE.
		5.00	Medical Genetics Series: Physiology Theatre. Prof. POLANI. "Chromosomal Genetics II."
9th	F	1.00	Clinical Lecture. Dr. HOUSTON. "Some Uncommon Disorders of the Oesophagus."

THE HEART AS A MUSICAL BOX*

By

D. N. ROSS

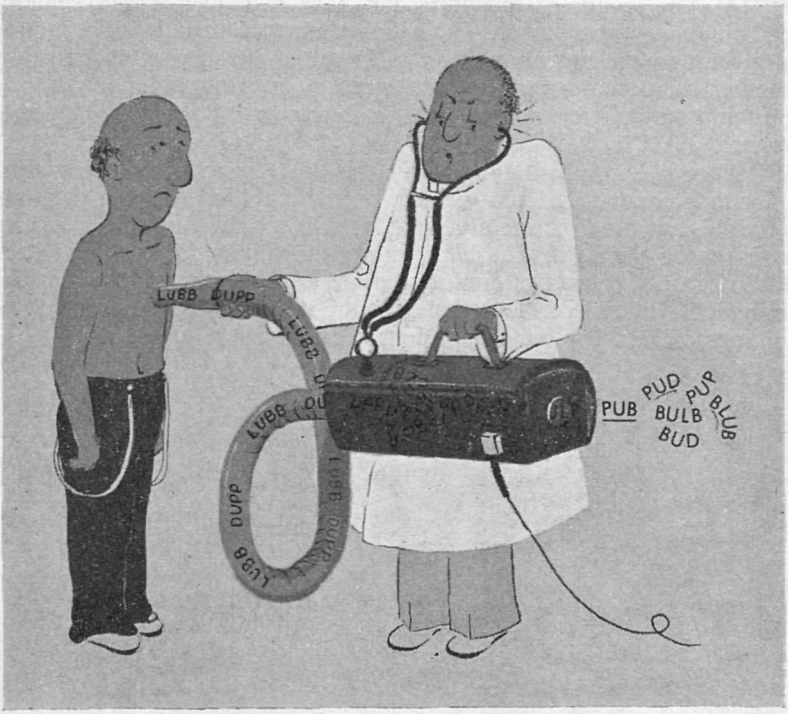
It is my considered opinion that the heart acts as a simple and reliable pump. I believe that the present techniques of learning about heart disease do not adequately recognise this straightforward fact. Cardiology is now beset with a plethora of ritual and jargon which frightens off the non-cardiological onlooker and obscures the workings of the pump. Opening snaps, clicks, and murmurs abound together with high-powered talk of cardiac indices, stroke work and raised end-diastolic pressures. Nevertheless the pumping mechanism is essentially a simple one, and this is daily confirmed in my experience by the fact that a single and uncomplicated pump takes over the entire circulation for many hours to enable me to work within the open heart. Consequently we should assess the heart's efficiency as we would a pump—chiefly by judging its ability to handle its work load (venous pressure and venous pulse) and by assessing its output (blood pressure and arterial pulse).

If you were investigating a faulty mechanical pumping system you would certainly look to see what it was putting out and pumping away, and of course your attention may well be drawn to the trouble by the abnormal noises that it made. The relative inaccessibility of the heart pump means we have come to rely on an analysis of the altered noises it makes to help us in our clinical diagnosis. This is where an understanding of the "musical box" comes in and particularly the mechanism of production of the normal heart sounds.

---

*Clinical Lecture given on 10th April, 1967.

Only too often the student buys, borrows or is given a stethoscope, is told that mitral stenosis is diagnosed by a low rumbling diastolic murmur and off he goes to listen hopefully to the precordium, just as I did, hoping to have a diagnosis pop out.



The stethoscope is a dangerous instrument and I believe we should be licensed to use it, after satisfying some properly enlightened and physiologically-minded examining body that we know what we are listening *for*.

Also, one of the most closely guarded secrets of auscultation should be divulged at the time of the handing over of the gold-plated stethoscopes, i.e. that your auscultatory guess is generally as good as the next observer's and provided you have a few basic facts at hand there is no divine or mystic secret handed down from on high by the Royal College of Physicians or the august British Cardiac Society.

There are one or two basic rules to this guessing game, just as with any other diversion, but these don't take too long to remember:

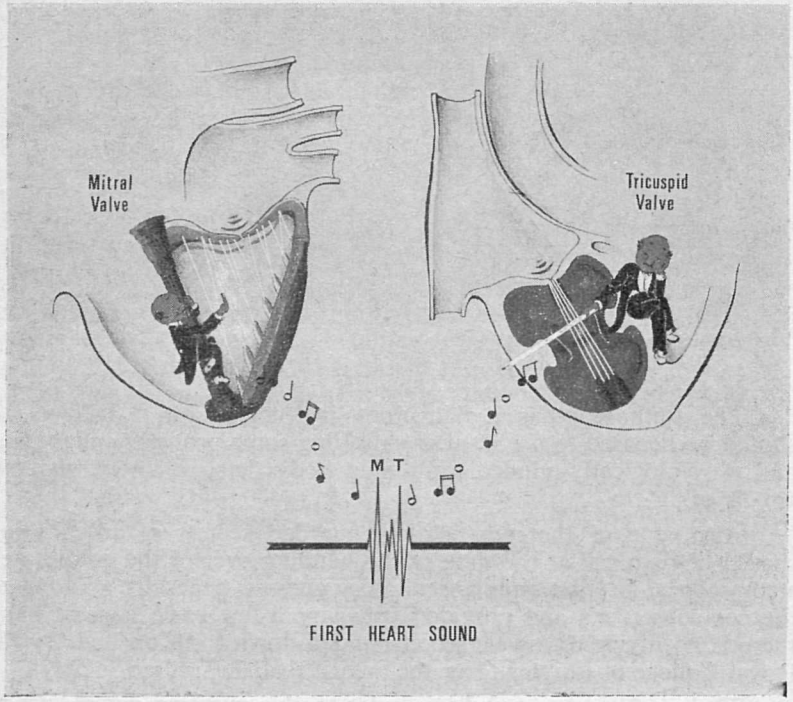
(1) a simple lightweight stethoscope without cumbersome end-pieces and gimmicks is the best for the beginner and even for the old hand at the game.

(2) The *loudness* of a murmur is not usually important and does not necessarily mean a severe lesion (a small leak with a high velocity or pressure is noisy and a lot of big leaks may make no noise at all, e.g. atrial septal defect).

(3) The loudness of *sounds* can be important just as the banging of a door indicates the increased force with which it is closed.

(4) The *length* of murmurs can have significance and suggests the length of time during which the abnormal turbulence is acting as a burden on the circulation. However, the shape of murmurs whether diamond-shaped, square, ejection or pansystolic comes into the realms of clinical experience, or if you prefer it, inspired guesswork.

When we come to talk about the heart sounds remember that all sounds emanating from the left ventricle also arise from the right ventricle, but are fractionally later from the right ventricle since for some reason the right ventricle is rather more languid in its activities. Both its rate and force of contraction are less than that of the snappily acting left ventricle. Nevertheless both ventricles put out the same volumes of blood if the circulation is to remain adjusted.

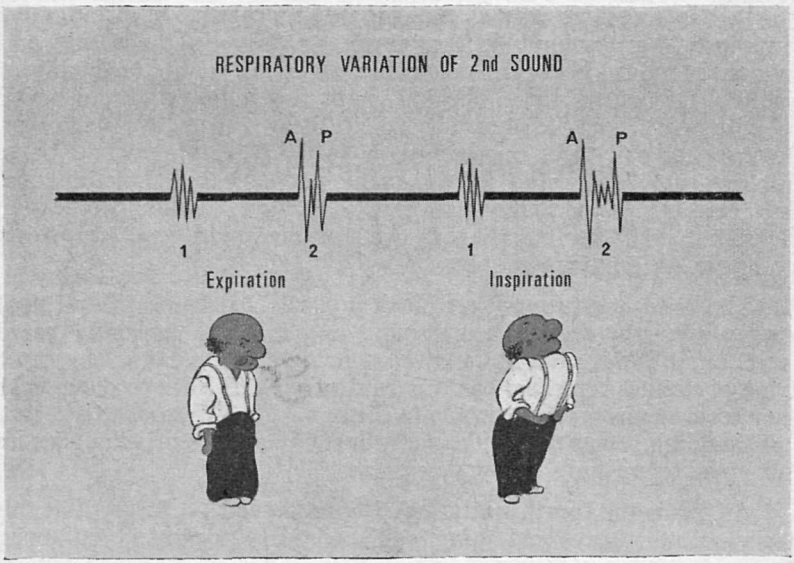


As a consequence of this delayed activity on the part of the right ventricle the first sound is normally split and is made up of the closure of the mitral and tricuspid valves in that order, the mitral component being first. Since the pressures on the left side of the

heart are higher than those on the right, the force of closure of the mitral valve gives a louder sound and tends to obscure tricuspid closure so that you and I hear really only one sound. In fact, the experts describe four components to the first heart sound, but that is real one-upmanship.

The second heart sound is a bit more complicated because of the effect of breathing on the volume of the normal venous return. In the first place the sound is also split into two components as is the first sound, the first component being the loud high-pressure closing sound of the aortic valve and the second component being the delayed and softer closure of the pulmonary valve.

Now as one breathes in, a considerably increased volume of venous blood floods into the right atrium and right ventricle due to the negative intra-thoracic pressure. This means that the somewhat lazy right ventricle has suddenly to cope with and eject an increased volume of blood and not unnaturally takes even longer doing it. The result is that the usually delayed pulmonary closure of the second heart sound is delayed still further in inspiration and moves back to its normal place on expiration. Hence the well-known respiratory variations of the split in the second heart sound. This rhythmical widening and narrowing helps one to hear it, whereas we are unlikely to hear the split of the first heart sound which does not have this respiratory variation.



Now it is also easy to understand that any pathological process delaying contraction of either the left or right ventricle (such as electrical blocks of the bundle of His), will disturb this normal

widening and narrowing of the second heart sound still further and it may, in fact, be a diagnostic point of importance.

You must remember to distinguish this delay or width of split of the second heart sound from the loudness of the sound. The loudness, as I have said, represents the force with which the valve door is slammed shut and with systemic hypertension the aortic or first component will be loud, and with pulmonary hypertension the second or pulmonary valve component will be loud.

Up to now we have spoken of the first and second heart sounds which represent closure of the heart valves. Opening of the normal valves normally causes no sound at all, but valves which are still flexible, and at the same time unable to open fully, may cause a snapping sound on opening as the valve substance tightens short of a full orifice. These opening sounds or opening snaps, as they are sometimes called, can, therefore, arise from any of the four heart valves provided they are both stenotic and still retain their flexibility. They not unexpectedly give rise to a sharp snapping sound and you will be most familiar with the opening snap of the mitral valve in mitral stenosis with a flexible valve. This opening mitral snap is heard best in the mitral area just at the time the valve opens, that is, near the beginning of diastole. In other words, you hear a sharp snapping sound just after the normal second sound, and unless you know what you are listening for you may otherwise regard it as the split of the second sound or a third sound.

Just in the same way as the stenosed mitral and tricuspid valve can cause sharp sounds as they open, so also do the aortic and pulmonary valves give rise to opening snaps just at the beginning of systole. Of course, these opening snaps are followed by an aortic or pulmonary systolic murmur when these valves are narrowed. However, to call them opening snaps (which they are) would be to give the game away and let too many people into the stethoscopic club secrets. Hence they are called ejection sounds or ejection clicks, but don't be fooled—they are opening snaps emanating from the aortic or pulmonary valves.

The third heart sound is a bit of a puzzle. It is a soft, dull thud coming after the second heart sound and is not a normally heard heart sound. It is said, not very convincingly, to be caused by rapid filling of the left ventricle, but it is worth trying to learn to distinguish because it means a left ventricle in distress. As I've said, it is a soft, dull thudding sound unlike the sharp metallic sounds of valve closure and opening we have so far discussed.

As far as the fourth heart sound is concerned I'd forget it at this stage—we must leave something for the clinical tutor to tell you about.

That leaves only the murmurs and it's here that the murk and fog lies thickest on your cardiological mystery tour. Murmurs simply mean turbulence in the blood flow and if the turbulence is important it very frequently gives rise to a thrill. A thrill is much more useful since it not only is easier to time, but indicates precisely where the

source of the turbulence arises, e.g. V.S.D. mitral, aortic or pulmonary valves. Having felt the thrill and located and timed it, it is easy to fit in the murmur. The trouble with our ears is that they are far too sensitive to sounds and can hear the murmurs conducted widely all over the precordium as a rule. I much prefer to localise the site of the turbulence with my hand and then listen for the confirmatory murmur.

In general, systolic murmurs are harsh and blowy and diastolic murmurs are low pitched and rumbling and more difficult to hear, but for goodness' sake don't start listening to them until you've a good idea of the diagnostic possibilities and know what you are listening for. Then listen consciously to the sounds first and lastly to the murmurs.

Just an example or two before I close, of the dangers of the unlicensed stethoscope. A patient comes up with florid aortic stenosis, syncope, angina and breathlessness, an anacrotic pulse, heaving left ventricle and systolic thrill conducted to the neck. Ignoring these precise diagnostic features, the stethoscopist claps his machine on the chest and says—"Ha! A diastolic murmur, important aortic regurgitation." Usually this is nonsense. If you think of a rigid calcified stenotic aortic orifice, it can't open—true. Equally well, it can't close, so that a diastolic murmur is implicit in the diagnosis and I for one would be surprised not to hear it in making a diagnosis of severe aortic stenosis. Important aortic regurgitation is diagnosed by the wide pulse pressure, by the hyperdynamic left ventricular impulse, and let me assure you the diastolic murmur may be almost inaudible where the blood rushes back through a virtually absent and non-obstructive or grossly regurgitant valve.

As another example, one has a case of severe mitral stenosis with a small volume fibrillating pulse, a palpable first heart sound (closing snap), and a diastolic thrill at the apex. Along comes the expert with his bell-shaped vacuum cleaner and hears a loud, blowing, systolic murmur and writes the case off because of severe mitral regurgitation. Probably he ignored the pulsating neck veins and liver and features of pulmonary hypertension which would have perhaps alerted him to the site of the origin of the murmur from the regurgitating tricuspid valve in the presence of tight mitral stenosis.

I hope you all remember the simple diagnostic rule you learnt long ago :

Inspect
Palpate
Percuss
Auscultate.

May I suggest a modification of this for use in diagnostic cardiology :

Inspect
Palpate
CEREBRATE
Auscultate.

90 Years Ago

May, 1877

The excavations that have been going on for the last fortnight in front of the Betts Museum, are for the reception of a new block of buildings in connection with the school. In the first place, what has hitherto been known as the Practical Physiology Room is to be pulled down, and the ground it covered will be thrown into the "Park". . . . In the basement on the left there will be a slight continuation of the "Catacombs", and all this underground system is to be ventilated by an air shaft supplied with gas burners, all the effluvium will thus be effectually disposed of. . . . The whole structure is to be fire-proof. . . . It is not yet specified to what uses the different rooms will be put.

50 Years Ago

May 19th, 1917

The strike of omnibus employees has made the Hospital more difficult of access than usual, but as we still have the use of the tubes and Hop Exchange trams, the situation is not really serious. If, however, as threatened, the strike extends to the workers on the tubes and trams, there would be some difficulties in going "up west" for men resident in the Hospital.

June 2nd, 1917

. . . Full use can be made of women in the female venereal departments, but they obviously cannot act as substitutes for men in the male departments. . . .

June 2nd, 1917

We are sorry to hear that the course of lectures on venereal disease delivered in Guy's during the month of May has been very inadequately attended. There can be no doubt that this has been due, not so much to lack of interest in the subject on the part of general practitioners, as to the disturbance and uncertainty caused by the great War Office blunder in calling up all medical men under 41 without reference to the medical authorities who control the supply of recruits for the R.A.M.C. Another obvious reason for the poor attendance is that most civil practitioners are at present grossly overworked.

June 2nd, 1917

Dr. A. F. Hurst is giving a Kinematograph Demonstration of War Neurosis at 107, Wardour Street, W., at 2 p.m. on Wednesday, June 6th, instead of a Clinical Lecture at Guy's.

OBITER DICTA

Dr. W*yte: "We are often blamed for stopping people having babies, but I have once been blamed for causing a woman to have a baby."

Telephone call to the *Gazette*: "Is C.S.S.D. still open?"

QUIZETTE : Physical Medicine

(answers overleaf)

1. Which of the following features are pathognomic of rheumatoid arthritis?
(a) Morning-stiffness; (b) Ulnar deviation; (c) A positive Rose-Waaler; (d) Radiological evidence of joint-erosion; (e) The sub-cutaneous nodule.
2. Which of the following conditions may complicate rheumatoid arthritis?
(a) Cardiac tamponade; (b) Laryngeal stridor; (c) Haemolytic anaemia; (d) Carpal tunnel syndrome; (e) Iritis.
3. Which of the following drugs may be used in the treatment of acute gout?
(a) Colchicine; (b) Phenylbutazone; (c) Sulphinpyrazone ('Anturan'); (d) Allopurinol; (e) A.C.T.H.
4. Which of the following joints of the hand may be affected in primary generalised osteoarthritis?
(a) The terminal interphalangeal joints; (b) The proximal interphalangeal joints; (c) The metacarpo-phalangeal joints; (d) The first carpo-metacarpal joint; (e) The wrist.
5. A man of 58 presents with pain and weakness in the upper arm and muscles. Blood tests show haemoglobin 11.3 g./100ml: E.R.S. 88 mm/hr. and a raised serum creatine phosphokinase. Which of the following diagnoses are possible?
(a) Polymyalgia rheumatica; (b) Polymyositis; (c) Multiple myeloma; (d) Giant-cell arteritis; (e) Rheumatoid arthritis.
6. In which of the following conditions is the serum alkaline phosphatase usually raised?
(a) Osteoporosis; (b) Osteomalacia; (c) Calcific tendinitis of the shoulder; (d) Multiple myeloma; (e) Ankylosing spondylitis.
7. In which of the following conditions may articular calcification occur?
(a) Relapsing polychondritis; (b) 'Pseudo-gout'; (c) Alkaptonuria; (d) Hyper-parathyroidism; (e) Scleroderma.
8. Which of the following conditions may present with acute pain in the shoulder (s)?
(a) Myocardial infarction; (b) Polymyalgia rheumatica; (c) Neuralgic amyotrophy; (d) Cervical spondylosis; (e) Ruptured ectopic pregnancy.
9. The treatment of choice for lateral epicondylitis ('tennis elbow') is:—
(a) Anodal galvanism; (b) Renotin ionisation; (c) Massage; (d) Local corticosteroid injection; (e) Surgery.
10. What is the most effective way of restoring the quadriceps muscle after meniscectomy?
(a) Faradic stimulation; (b) Interrupted galvanism; (c) Proprioceptive neuro-muscular facilitation; (d) Resistance-exercises; (e) Hydrotherapy.
11. How soon should rehabilitation commence in the case of hemiplegia following cerebral thrombosis (assuming a full return of consciousness if lost or impaired initially)?
(a) At once; (b) After 48 hours; (c) After 72 hours; (d) After one week; (e) After two weeks.
12. In which of the following conditions may breathing exercises and/or postural drainage be advantageous?
(a) Ankylosing spondylitis; (b) Chronic bronchitis; (c) Asthma; (d) Pleural effusion; (e) Fibrocystic disease.
13. In which of the following conditions may ultra-violet light be indicated?
(a) Acne; (b) Psoriasis; (c) Varicose ulceration; (d) Systemic lupus erythematosus; (e) Recent haematomata.
14. In which of the following conditions may electromyography provide useful information?
(a) Pseudo-bulbar palsy; (b) Cerebellar ataxia; (c) Motor-neurone disease; (d) Peripheral neuropathy; (e) Dystrophia myotonica.

QUIZETTE ANSWERS

We would suggest, as the answers may for reasons of space be printed rather closely together, that readers answer all the questions before checking on the answers. We appreciate that the test is considerably more difficult this way.

1. **e**

The sub-cutaneous nodule, which occurs in 25 per cent of patients, is the only specific lesion of R.A. Morning-stiffness is a feature of chronic inflammatory arthritis in general. Ulnar deviation may result from any chronic arthritis of the metacarpo-phalangeal joints. The Rose-Waaler may be positive in various collagen-diseases, also chronic infection. Erosions may occur in numerous other disorders.

2 **a b c d**

Carpal tunnel syndrome is a frequent and often overlooked complication of R.A., the others are rare. Rheumatoid pericarditis is probably more common than realised and may occasionally cause tamponade from effusion or progress to constriction. The crico-arytenoid joints may be involved in R.A. and very occasionally laryngeal stridor may result. Haemolytic anaemia may be the most prominent feature of Felty's syndrome. Iritis is not a feature of adult R.A., and its presence is more suggestive of ankylosing spondylitis or Reiter's disease.

3 **a b e**

Drugs which depress the plasma uric acid have no place in the treatment of acute gout which they tend to aggravate. They often provoke acute gout when first given; for this reason prophylactic colchicine or phenylbutazone should be administered *concurrently until the plasma uric acid is* normal and all tophi have disappeared. A.C.T.H. is reserved for the very rare occasions in which acute gout does not respond to colchicine, phenylbutazone or indomethacin.

4. **a b d**

Although it is now 15 years since Kellgren (Kellgren and Moore, 1952) described the *condition of primary generalised osteo*-arthritis, these cases are still frequently misdiagnosed as R.A. and treated accordingly.

5. **b**

Any of the conditions listed may present with similar symptoms and a grossly raised E.S.R., but the raised serum creatine phosphokinase indicates necrosis of voluntary muscle fibres which is consistent only with polymyositis. At this age polymyositis is usually secondary to carcinoma of the alimentary tract or bronchus.

6. **b**

7. **b c d**

'Pseudo-gout' (McCarthy et al, 1962) is a syndrome characterised by recurrent attacks of acute arthritis associated with the intra-articular phagocytosis of calcium pyrophosphate crystals. X-rays may show calcification of the menisci together with a fine line of calcification on the surface of the articular cartilage. This has led to the *synonym chondrocalcinosis articularis* (Zitnan et al, 1963). The condition occurs most often in a familiar form unassociated with any underlying disturbance of calcium metabolism, but it may also be a feature of hyper-parathyroidism or haemochromatosis. The articular calcification seen in ochronosis associated with alkaptonuria is well known.

8. **a b c d e**

9. **d**

Fancy electrical treatment has no place in the modern treatment of soft-tissue lesions, most of which respond well to accurately placed local corticosteroid injections. Surgery should be reserved for those rare cases of chronic tennis-elbow not responding to injection.

10. **d**

11. **a**

Rehabilitation in the broadest sense of the term should begin at once, and re-education in walking and other activities at the *earliest possible opportunity. It is still all* too common for hemiplegics to be left lying around until contractures and bed-sores have developed before the physiotherapist is asked to see them.

12. **a b c e**

13. **a b c**

U.V.L. is strongly contra-indicated in S.L.E. in which exposure to sunlight may lead to a rash or even a generalised relapse. U.V.L. is useless for haematomata or other deep lesions as it does not penetrate the skin.

14. **c d e**

In general terms electromyography is of no value in lesions proximal to the anterior horn cell.

REFERENCES

Kellgren, J. H., and Moore, R. (1952). Brit. Med. J., **1**, 181.
McCarthy, D. J., Kohn, N. M., and Faires, J. S. (1962). Ann. intern. Med., **56**, 711.
Zitnan, D., and Sit'aj, S. (1963). Ann. rheum. Dis., **22**, 142.

Compiled by B. A. LATHAM.

CORRESPONDENCE

Medicine at the Crossroads

SIR,—"The English," said Voltaire, "have a hundred religions but only one sauce." Had he been alive today he might have said that they had a hundred medical degrees but the same basic training, at whatever seminary of medical learning it may have been acquired. The Americans, I believe, laugh at us for this, perhaps because it is responsible for making the profession of medicine the most intellectually snobbish of all professions in this country. In America, as soon as a medical student arrives by examination at the point where it is considered that he is fit to have the general public let loose on him, he is awarded the M.D. degree, and "there's an end on't" as Dr. Johnson would say. Not so in England: he goes on and on taking degrees of the greatest difficulty to acquire and, if medical knowledge is advancing at the rate which it is supposed to be doing, he is imbibing knowledge which must surely be obsolescent even as he struggles to acquire it. One of the pastimes of the ageing is to read obituary notices and to read those in the B.M.J. is to me a sad business, because they so often record the demise of young men of brilliant academical qualifications, killed in my opinion by the long and laborious efforts to acquire degrees. A young man, several years my junior in age, started Biology at the same time as myself and acquired about every degree, Medical and Surgical, in London, as well as D.L.O. and D.P.H., and who, as I read in the B.M.J. a year or two ago, dropped down dead whilst fishing. It is true he was 64, but who can doubt that this was a case of cause and effect.

A quoi bon? one might say. Of what use is all that effort? I never read anywhere during the years that he set the Thames on fire, if I may use a now-archaic expression, but I noticed that he was modest enough to do five years' work in his brother's (conjoint) practice in the industrial North.

Is Medicine really at the Crossroads, at the point of "breakthrough" (that word of protean use and significance) or is it the same old Medicine, fitted up with all kinds of wonderful life-prolonging, but not life preserving, devices and puffed up with excessive publicity? Would it not be true to say that, since the discovery of the sulphonamides and the antibiotics some twenty years ago or more now, there has been nothing of comparable value medically-speaking. We have the steroids of course, but to a mere retired onlooker who still reads medical journals these seem to be hedged about with various inhibitions of greater weight than those which advise caution in the use of the above two remedies.

In the 1920/30 era, the great surgeon of the day, Moynihan, said that surgery had reached its zenith, a statement which up-and-coming young surgeons would later scoff at no doubt. He also used to say that he was a surgeon by profession, but a physician at heart, and is it not true that much of surgery is, in fact, what we might call medicine 'manqué'. There must be a limit to the number and kind of procedures which can be carried out on living human tissues, even though a distinguished member of Guy's staff said in an address a year or so ago, when speaking of some surgical procedure: "We thought we knew in the 1930s." But will someone not be saying something similar in the year 2000. "We thought we knew in the 1960s."

Is it natural to attach inorganic materials to organic matter, and expect it to last, as is done in heart surgery? When I read about the Medicine of today, and what, apparently, it is to become tomorrow, I am amazed that I should have staggered through 40 years of single-handed general practice, without a trail of death behind me, and the vituperation of countless bereaved families. Not a bit of it, but I can remember that one member of my family two or three years ago was rendered unconscious by some wonderful "new tablets" in a London teaching hospital (not Guy's).

Pertinax seems to think that the course of the new scientific medicine would be smoother if only the G.P. spent more of his time within the walls of some hospital. "What," may one ask, "would he do there apart from asking the usual banal, 'How are you?' " Would he then rummage through the bed letter with its hundred and one reports and, if so minded, would he be allowed to change the treatment? Or would he meekly take the specimen of urine left for him and ascertain if it contained sugar or/and albumen.

During this interlude in his day's work, with his mind perhaps tormented by numerous duties outside waiting to be done, how much good would he be doing to himself, his patient in the bed, or possibly numerous other patients awaiting his arrival outside the hospital. In his article this week (15.4.67) Pertinax as a great protagonist of the G.P. in the hosptial at all costs, condemns himself by pointing out that the G.P. hasn't a fraction of the time necessary for treating the ever-increasing number of mental cases that fall into his net.

We have yet to find out how many people are going to die as the result of our new remedies, (not forgetting 'the pill' with its very, very big question mark). We have had one horrifying awakening in thalidomide, and other amazing "breakthroughs" will no doubt in time disappoint those who are putting them to the test. But we must suppose that, like the "Show", Medicine must go on.

And perhaps here we may insert a note about the cheap cant, usually on the part of would-be well-informed lay people, about "prevention". Any doctor worth his salt will, so far as he can, advise a patient how in future to avoid what he may be suffering from at the moment; but how can he give advice about all kinds of hypothetical illnesses from which his patient *might* suffer. Astronomical figures are usually given for the years which it has taken Man to reach his present state of physical and mental development, and very imperfect they are in both respects. Coming down to an anticlimax, in point of time, how many years is it going to be—speaking of "prevention"—before "Homo" (with the usual "sapiens" tacked on to his name) pays any real heed to his doctor's advice about excessive smoking and excessive alcohol? These are today, with the exception of road accidents, probably responsible for more real misery than any other cause, because they are preventible and, to quote the great Moynihan again: "If preventible, why not prevented?"

But in sum, like the fictitious Rosa Dartle, "I merely want to know."

G. L. DAVIES

Oakfield,
Hay-on-Wye,
Hereford.

Special Answer

SIR,—May I write and concur with your views in the article on "Sex is here to stay" (*Gazette*, Apr. 15, p. 183)?

Moral judgements of the nature to which you refer, which have been made in several journals as well as in the lay press, are made, one thinks, on too slender evidence. There are so many variables in the human environment that it is extremely difficult, when studying these matters of sexual behaviour, to make true evaluations or valid comparisons between one generation and another. It is noteworthy that Kinsey[1] himself stated that there was little difference between the sexual activity of the recent N. American male population sampled and that of the generation before, the main difference being that the present generation was able to indulge in coitus with girl-friends instead of prostitutes (surely a more healthy activity!).

Statistics are vulnerable. For example, a mere rise in the number of unmarried mothers is as likely to be due to fewer young pregnant mothers being dragooned into marriage, as to any other factor. Similarly, everyone knows that there is a relationship between the increase in the numbers of indictable offences and the recent notified increase in so-called venereal disease, and that similar social attitudes may have helped to mould both sets of individuals. But Professor Ferguson[2] made the cogent remark that the high rate for delinquency in the 'teens and early 20's in Glasgow was not reflected by a high rate when these people reached maturity in the late 20's and 30's. What had happened, he asked, to the censurable boys and young men when they became settled citizens of more mature years? One could ask this same question *vis a vis* sexual behaviour. Professor Carstairs[3] in a talk, and referring to his Reith Lectures, made the point that a limited promiscuity (one stresses the word *limited* and one would prefer an alternative to the word promiscuity) may even be a worthwhile preliminary to a happy marriage. If some people agree, then those who write in the vein of the article which you criticise have either not read these views or cast such a cold eye as not to refer to them.

Anthropology[4] supports your statement that marriage is not necessarily the only possible worthwhile sex relationship, and there are some extremly well documented studies amongst primitive racial groups disposing of the glib arguments which you rightly hold in question. Nevertheless there are two statements which must be made: firstly that the family group is irreplaceable as a milieu for the healthy development of the child and its maturing responsible attitudes. Secondly that, although there is a great deal of anthropological evidence pointing to the harm caused by sex-repression, there is evidence (anthropologically less universally supported[5] but culturally stronger) of the importance for some limitation of coitus.

Much of the quarrel turns on the meaning of the word 'promiscuous', and its use in this setting is inappropriate with its overt meaning of 'lightheartedness'. As you rightly point out, though, it cannot simply be equated with non-marital coitus as such.

Mankind through the ages has not been averse to considering that a strong emotional commitment (with affection) is more often than not a moral one. Which is what this is all about?

A. S. GRIMBLE

Department of Venereology
Guy's Hospital,
London, S.E.1.

REFERENCES

1. Kinsey *et al.* Sexual Behaviour in the Human Male; and Female. Saunders 1948.
2. Ferguson, T. The Young Delinquent in his Social Setting. Oxford University Press 1952.
3. Carstairs, G. Vicissitudes of adolescence. *Listener* 1962; *Listener* 1966.
4. Malinowski, B. A Scientific Theory of Culture. Oxford University Press 1960.
   — — Sex and repression in Savage Society. Routledge 1927.
   — — Sexual Life of Savages. Routledge 1926.
   Ford, *et al.* Patterns of Sexual Behaviour. Eyre & Spottiswoode 1952
   Mead, M. Coming of Age in Samoa. Penguin 1943.
5. Unwin, J. Sex and Culture. Oxford University Press 1934.

What Is Absolute ?

SIR,—The problem that has arisen from your editorial, "Sex is here to stay" is surely not concerned solely with the rightness and wrongness of pre-marital intercourse, but with a more fundamental issue. This fundamental issue lies in the definition of rightness and wrongness. Prof. de Burgh has said, "If ethical standards rarely express changing adaptations to the this-wordly requirements of a particular society in a particular epoch of its history, the pretensions of these ethical standards to universal validity are null and void." Premarital intercourse, casual or responsible, cannot be the grounds for disapproval or condemnation if such disapproval rests solely upon the changing opinions of vacillating man. Condemnation or criticism of another man's activity can never rest upon a basis of temporal and non-absolute (ie. relative) principles of right and wrong. The criticism for instance of Hitler's action of saying one thing at Munich and contradicting it by his energies a few days later, is devoid of ethical justification if our basis of criticism is one of ethical relativism. We may consider his action ill-advised but we have no right to pass moral condemnation on his action when our basis of judgment is related to the principles of rightness and wrongness in existence at that time.

This applies in the sexual realm. The only basis upon which criticism of pre-marital intercourse can rest, is the basis of other-wordly, changeless, eternal standards; standards which are not man-made, and not altering with each society in existence. The only standards that can be applied with universal validity are other-worldly standards. Such standards necessitate revelation, since even those

produced by man's highest philosophical cogitations at their best are still only this-wordly. Thus anyone passing criticism on pre-marital intercourse must be able to base his criticism on relation.

Historic Christianity declares that such a revelation has been given, not only in an eternal, absolute law but in a Person who personifies the law revealed. Only such a Person can ultimately pass judgement on man's conduct. Mere man expressing his own concept of rightness and wrongness deserves no audience from other men, however excellent his concept may be. Nevertheless, the man that defines rightness and wrongness by an other-worldy standard received by revelation from man's Creator, who personified the perfection of such a law, surely deserves a hearing.

Yours, etc.,

FINN COSGROVE

East Wing,
Guy's Hospital, S.E.1.

[*Eds*: *Who held the pen*?]

Haunting Casualties

SIR,—I enter the correspondence on "Sex is here to stay" rather late. The *Gazette,* too, was a little tardy. Sex came to stay when Homo sapiens first emerged as a species. That which has arrived more recently is increasing freedom of discussion of the accompanying problems, and a less mealy-mouthed approach to the sexual practices in which most of society indulge. It remains to be seen, however, if this recent arrival is here to stay. The fashion has been in before and doubtless will be in again.

The three correspondents to your last issue asserted suppression to be the only way of dealing with the tension within us called sexual drive. Only when we form relationships which the church and its handmaiden, society, accept, is relase permitted. Two thousand years of Christian domination have not succeeded in solving the problem in this manner. Here, where our social standards pay lip service to Christian morality, we have not become increasingly chaste over the years, we do not produce fewer illegitimate children, and do not commit less adultery.

Christian sexual morality does not fit the facts of society. It fails to prevent what it views as certain types of undesirable sexual activity, but persuades society to condemn whatever aspects of this activity come to light. Surely the fault in our society is not too much acceptance of sexual irregularity, but insufficient acceptance of human beings. We should be ashamed of the way in which the unmarried mother and her child are received into society. We should be ashamed of the whole rag-bag of social conventions which amount to the sentiment—it doesn't matter what you do, it's getting caught that counts.

Until we come to terms with what we are, instead of theorising on what we ought to be, the casualties of Christian sexual morality will continue to haunt us.

Yours, etc.,

DAVID BOULTON

The Caversham Centre,
25 Caversham Road,
N.W.5

It's Improper

SIR,—I have now read the remarks in Passim under the heading of "Sex is here to stay" in your issue of 15th april. I deeply deplore such views and consider them wholly improper in the *Guy's Hospital Gazette.* I am entirely in favour of male—female egalitarianism. The vast majority of young men who marry, wish to marry virgins. Women have an equal right to expect their husbands to be the same, and, by the Grace of God, this is possible for the male. Our Lord, when faced with the question of the women taken in adultery, laid the responsibility squarely on the hypocritical males. I would that every girl should lay to heart Kipling's lines in "The Ladies".

"An' I wouldn't do such, 'cause I liked 'er too much,
But—I learned about women from 'er!"

When the writer of the article is a little older and has taken his professional duties seriously he will be appalled by the misery resulting from laxity of morals.

I am an old man, who was blest with 40 years of married happiness, and who is now waiting to be re-united with his soul's mate for eternity.

Yours, etc.,

KENNETH HOOPER

Shrewbury Cottage,
Cranbrook, Kent.

"Would You Send Your Sons?"

SIR,—Amongst the views, advice and facts so helpfully offered in the *Gazette*, I doubt if the following point of view has been expressed before. It may come now as a timely comment on the current discussions of sexual mores amongst students.

When parents send their sons to Guy's, often to carry on a long family tradition, as individuals they are on their own. If, gradually, they form moral codes differing from those in which they were raised, the parents have little or no influence in the matter any more; many students are financially independent and they find themselves able to choose—perhaps for the first time in their lives.

My three sons went to Guy's and to my great regret one made an unsuccessful marriage for the following reason:—

When he slept with another female student, apart from the risk of a pregnancy, he did not realise, being 26 years old and perhaps a little immature, that the girl had a designing mother in the background.

When our sons leave school, and perhaps home, to become Hospital Students, they are, in a sense, exchanging one Ivory Tower for another. Could we try and persuade them to spend more time in **thinking** about the consequences of gratifying their passing sex impulses, at the cost of committing them to marriages which soon became stale? Grow up first, sons!

Yours, etc.,

EX-GUY'S SISTER

Harley Street,
W.1.

[*Eds*: *But who did what, and to whom*?]

Another Guise?

SIR,—This will probably make no difference to whoever is concerned, but is is worth a try—it might just penetrate.

At 1 p.m. on 19th May 1967 I noted my *B.M.J.* and *Lancet* in my personal rack in the East Wing; at 1.45 p.m. after lunch I went to collect them, and found an empty rack. I believe that this has been going on to a greater or lesser degree in the students' racks for a long time now.

I can only assume that the person responsible is qualified, or near qualification and wanted to look up jobs. He could be a clinical student, but is unlikely to be pre-clinical. It shakes one to think that this man will soon be practising medicine.

These magazines were removed, in their wrappers, from my personal postal rack, the only place where my post can be put, and where it has to be put during the period as houseman, when the hospital is my home. One only hopes that the same thing does not happen to personal post.

I am sorry to have to say that a lot of this sort of thing goes on at Guy's, but unfortunately it is true. Perhaps it is inherent in any large institution, but it is terrible to see these things happening where only medical and dental students or staff can be involved.

Well, I must get on and write to the *Lancet* and *B.M.J.* so that I may get repeat copies. I hope my original copies are being of use to somebody.

Yours, etc.,

J. S. GREGSON

East Wing,
Guy's Hospital,
London, S.E.1

Well?

SIR,—How delightful it was to see Mr. G. L. Davies' article on music in a recent edition of the *Gazette*.

I feel that one or two points ought to be clarified. Mr. Davies' Gods clearly enter Valhalla somewhat later in the Ring than most. I'm also not sure whether Edvard Grieg, that most Norwegian of composers would be flattered by being attributed with composing 'The Ride of the Valkyries'—the true Bayreuth sound, if ever there was.

Otherwise, one would only agree to be exceedingly grateful—May we please have more in general on the Arts?

HEDLEY BERRY

St. Christopher's,
208 Long Lane,
S.E.1.

How's That?

SIR,—I see the Pilgrims of Reigate along with eleven Dragon Flies are to throw leather and bend willow with Guy's Men of Sport on their greens of 22 paces on NOT ONE but TWO NIGHTS in May (ref. Sports Diary, 13th May, 1967).

I look forward to the Sports Correspondents' write-up on these two "Battles" and I offer him my torch to bring brightness on his paper in the reflection of the SIGHT SCREEN (if he can find it!)

Yours, etc.,

ERIC LOOMES

Counting House,
Guy's Hospital, S.E.1.

Chinomania

SIR,—Chinomania (the Ch. is soft) bears the same relation to Pekinology that the Great Wall does to the Bamboo Curtain.

Yours, etc.,

J. D. ELLIS

Crosslyn,
Elm Walk,
Farnborough Park,
Orpington Kent.

Coherent Concern

SIR,—Comments in the Nursing Section of the *Gazette* of 15th April on "Comfort under the Modern Lamp" made us think.

Concern, in its broadest terms is a major part of the expertise of many professions in hospital. Of recent years the role of everyone working with ill people has been thrown into confusion by changes in both medical knowledge and in society.

In the article the problem is presented as one for nurses. Is this in fact so? Surely a blending of the professional contributions is necessary if the patient is to feel cared for in a *coherent* way, and to achieve this we need to reach a better understanding of what each has to offer.

PAM SERVICE
PAT CORBY

Department of Medical Social Work.
Guy's Hospital.

Vive la Differance!

SIR,—I agree with Messrs. Scholefield, Briggs, and John that all students should wear white coats. (*Gazette* May 15th.)

There is, however, one drawback. The patient will never be quite certain whether the wearer of the white coat is a young man "going in" for a doctor, or a painter going out for a pint.

EMMANUEL ROBINSON

14 Bronwydd Avenue,
Penylan,
Cardiff.

NURSING SECTION

Report upon the Annual General Meeting of the Guy's Hospital Nurses' League

It was a beautiful summer afternoon on Wednesday, May 10th, when the Guy's Hospital Nurses' League held its 67th Annual General Meeting.

Prior to the meeting, Evensong was held in the Chapel. The Service was conducted by the Chaplain and the lesson read by Staff Nurse S. M. Baldwin, Secretary of the Nurses' Representative Council. The sermon was preached by the Archdeacon of London, The Reverend M. C. Sullivan. A choir of the Musical Society, conducted by Mr. Stephen Coles, gave very lovely support with the singing, and rendered an anthem, Cantate Domino, by Guiseppe Octavio Pittani.

The meeting was held, as usual, in the Physiology Theatre. The Chairman of the League, Miss F. Taylor, welcomed the President and all members, and expressed the indebtedness of all members to the Honorary Officers—The Honorary Secretary, Matron; the Assistant Honorary Secretary, Mrs. G. Blackburn; the Honorary Treasurer, Mrs. J. B. Blaikley—all of whom give tireless work to the League.

The President, Miss E. E. P. MacManus, C.B.E., took the Chair, and welcomed Dr. P. J. Helliwell as the new Superintendent. Miss MacManus regretted the absence of the Vice-Presidents—The Dowager Lady Cunliffe and Lady Robens, both unable to attend.

The Honorary Secretary presented her report and welcomed the members. Matron stated that 49 members had joined the League since the new arrangements for membership had been brought into force. Thanks and appreciation for her unstinted work on the Journal were given to Miss Myra Calvert for the work done on a Herculean task.

Matron congratulated the three people who had received the award of the Sir Cosmo and Lady Mabel Bonsor Scholarship for 1967: Mrs. Daphne Heinen (née Walton) (Guy's, 1955) to follow a Diploma Course in South Africa; Miss Dorothy Chapman (Guy's, 1966) now studying Social Services at Birmingham University; Miss Barbara Lunn (Guy's, 1956) to assist with a Paediatric Travel Tour in Israel.

Matron went on to mention that the Nurses' Representative Council had celebrated its Centenary meeting in April and a buffet lunch had been given in celebration. The recruitment of Student Nurses had been good and Matron mentioned that plans to include boys within the School of Nursing in 1968 were now proceeding.

Miss Molly Farnsworth proposed the adoption of the Honorary Secretary's report and was seconded by Miss Wendy Anscombe.

Mrs. Vivienne Blaikley, the Honorary Treasurer, presented the Balance Sheet and mentioned particularly the Benevolent Fund. Miss E. A. Opie proposed the acceptance of the Balance Sheet and was seconded by Mrs. E. M. Pitt.

Dr. P. J. Helliwell thanked members for his kind introduction and welcome to the League and gave a short report on the events and progress in the Hospital during the past year. The upheaval in the Park, he explained, was essential to the new Tower Block, and at the moment the tunnel was being widened from Hunt's House to Guy's House for the purpose of being able, in the future, to re-route all the main supply services underground.

An Omnibus vote of thanks was then proposed to the Honorary Officers and members of the Council, the Catering Staff and Staff of the Nurses' Home by Miss J. Page, and seconded by Mrs.R. Beard.

A very good tea was then served in the Nurses' Home although in the regrettable absence, due to illness, of Mr. Kingston, M.B.E., the Catering Officer.

A number of guided tours ensued and included a variety of areas where both growth and restoration of the Hospital could be fully assessed.

Throughout the afternoon a crêche was maintained for the benefit of League members. Twenty-nine young children were fully employed, and it is to be hoped that a proportion of these will be able to assist with the progress and stability of Guy's in the year 2000 !

STAFF CHANGES AND APPOINTMENTS

APPOINTMENTS

S/N J. Bruck (née Widlake) (Guy's 1939-44), to Nurses' Health Service Clinic.
S/N S. M. Cook (Radcliffe Infirmary, Oxford), to Main Theatres.
S/N P. Farrell (née Darnell) (Guy's 1958-63), to Introductory Course.
S/N M. Porter (Royal Sussex County Hospital, to York Clinic.
S/N F. Spencer (King Edward VII Hospital, Windsor), to York Clinic.

DEPARTURES

C/N A. Watson, in charge of Nursing Auxiliaries.
C/N G. Bailey, from Queen Ward.
C/N M. Gunn, from Medical Night Duty.
S/N A. Head, from Christopher Ward.
S/N J. M. Lenne, from Main Theatres.
S/N H. S. Side, from Samaritan Ward.

NOTICES

British Dental Association Annual Conference, Birmingham, 1967.

Guy's Alumni Luncheon

Arrangements have been made for this function to take place at the Staff House, University of Birmingham on Wednesday, July 26th at 12.30 for 1.00 p.m.

Will any members who wish to attend kindly notify Mr. R. F. Pusey, 51 Calthorpe Road, Edgbaston, Birmingham, 15, before July 1st so that reservations can be booked.

Guy's Hospital Society: East Anglian Dinner, 1967

The Guy's Hospital East Anglian Dinner for 1967 will be held at the Old Library, Pembroke College, Cambridge at 7.30 for 8.00 p.m. on Saturday, 17th June, 1967. If any Guy's men in East Anglia have not received a notice of this dinner and would like to come will they please write to Dr. A. Batty Shaw, 41 Newmarket Road, Norwich.

Sports Day, 1967

Sports Day '67 will be held on Saturday, 17th June at Honor Oak Park commencing at 2.30 p.m.

There will be several novelty races and side-shows as well as the serious events to provide a variety of amusements. For the non-athletic members of the Guy's community the bar will be open.

I hope that the afternoon will be well supported and prove to be a great success for both participants and observers alike.

In the evening the sports Day Dance will be held in the East Wing from 8.00 p.m. until 11.30 p.m. and not at H.O.P. as has been the custom.

Sports Day is the only occasion when the whole of Guy's are invited to compete together, and I hope as many as possible will try to attend to make it a memorable day.

Those wishing to compete in the serious events should consult the Athletic Club's notice board for further details

Anyone who would like to assist in helping during the afternoon should contact me via the Athletic Club pigeon hole.

M. BATES
Sports Day Secretary

Photographic Society Exhibition

In the past, the Society has tended to neglect its role as an artistic organization. Many members feel that something is needed to stimulate them to produce good photographs. It was therefore decided that an exhibition should be held. This will open on Thursday, 29th June. All subjects will be accepted for display; and the only condition for eligibility is that all prints are at least $6\frac{1}{2}$ ins. by $8\frac{1}{2}$ ins. (whole plate). There is no limit on the number of entries.

One need not be a member to exhibit your work in this exhibition, indeed photographs from all personnel at Guy's will be very welcome.

All exhibits should be ready for collecting by June 27th at the very latest. Forms may be obtained from the Hon. Secretary, Photographic Society, c/o East Wing.

SPORT

GOLF

In the London University Golf Championships Guy's again emerged as winners of the Beveridge Cup, presented to them by Mr. Nils Eckhoff, the President. The best three scores from each College Team were considered for the Championship—for Guy's:

D. Adams, 76 and 76.
P. Ellis (Captain), 85 and 76.
D. Elliott, 86 and 77.

In the Eckhoff Cup (awarded for individual performances), D. Adams took second place with 152.

SOCCER

Professor Haslewood, taking the Chair at the A.G.M., congratulated the Club on winning the League Trophy for the first time in the Club's history. Although they had not possessed the individual brilliance of the 1963 side, they had relied upon functioning as a unit. He stressed the importance of a good reserve side, especially as Guy's have entered the Premier Division of the University of London.

Ian Nash was thanked for his term as Captain.

The following Officers were elected for 1967-68 season:

President: Professor G. A. D. Haslewood, D.Sc., Ph.D., M.Sc., F.R.I.C.
Vice-President: Professor Butterfield, O.B.E., D.M., F.R.C.P.
Mr. J. B. Blaikley, F.R.C.S., F.R.C.O.G.
Mr. A. Stewart, B.D.S.
Mr. R. Hayward, Esq.
Captain: David Lindridge.
Vice-Captain: Ian Nash.
Hon. Secretary: R. Davey.
Hon. Fixture Secretary: R. Lovell.

HOCKEY

In the absence of Professor Butterfield, the President, Dr. Scott, took the Chair at the A.G.M.

The Captain, M. I. Appleby, disappointed by the 1st XI record of winning only six of their 27 games, commented that the side had been young and inexperienced. Although scoring good wins over Wimbledon and Kingston, they had missed their opportunity in the Cup by not defeating The London at their first encounter, who subsequently included Lawson, their international forward, in the replay. He believed that an experienced ex-Hockey player to coach them would be very beneficial. Turning to the Hockey Festival, he expressed the importance for Guy's to soon score a victory in this competition—an unachieved event for three years. C. J. Hunter-Craig and M. Knight were thanked for umpiring throughout the season.

The following Officers were elected for the 1967-68 season:

President: Professor Butterfield.
Vice-Presidents: Professor R. D. Emslie, B.D.S., F.D.S., M.Sc.
Dr. G. W. Scott, M.D., M.R.C.P.
J. C. Gazet, Esq., M.S., F.R.C.S.
C. J. Hunter-Craig, Esq., M.A., M.B., B.Chir.
A. Campbell, Esq., B.D.S., Dip. Orth. F.D.S.
Captain: S. Cripps.
Hon. Secretary: M. Dodd.
Hon. Match Secretary: C. Pearson.

CRICKET

The rain has intermittently forestalled the cricket fanatics—with only five games played out of eleven.

The Wanderers provided Guy's with a comfortable win of 55 runs—Swift scoring 71 and Watt-Smith 3—21. But Honor Oak Park forced Guy's into producing a poor batting performance, with Wilkinson, a Kent player, taking 6 for

8 for H.O.P. However, Guy's fared a little better with the bowling, eventually losing by six wickets!

So, after playing four games Guy's were presented with the second round of the Hospitals' Cup—against Westminster—a victory! After taking the field with nine men for the first four overs and producing a rather shaky batting performance they find themselves in the Semi-final against St. Thomas'.

DIARY

CRICKET

May 27.—Dragon Flies. Home. 11.30 a.m.
May 29.—Crofton Park. Home. 11.30 a.m.
May 30.—Incogniti. Home. 11.30 a.m.
June 3.—Dover. Away. 2.00 p.m.
June 4.—Highland Court. Away. 11.30 a.m.
June 10.—Teddington. Home. 2.30 p.m.

CRICKET

GUY'S v. THE WANDERERS

At H.O.P. Wednesday, 1st May, 1967

Result: won by 55 runs

After the frustration of watching rain wash out the previous two games, it made a welcome change for Watt-Smith and Thomas to open the innings under a cloudless blue sky. Watt-Smith lived dangerously before being dismissed in a manner that had always seemed likely, being caught in the covers off an intended drive. After a promising innings, Thomas soon followed, and then Chase was unluckily adjudged l.b.w. on the front foot. Three more wickets, including that of Silk for an enterprising 32, fell before lunch when the scoreboard read 104 for 6, the result of some undistinguished batting on an easy wicket.

The last four wickets added 72 runs in an hour after lunch, mainly the result of a fine innings by Swift, who was last out for 71.

At tea, the Wanderers had made 37 for 3, a commentary on the tight, accurate bowling by Crafts and Beacham. After the interval, wickets fell with surprising regularity until, with over an hour still to go, the last-wicket pair came together. That they managed to survive for all but ten minutes, when Crafts ended their stand, was due to a combination of sensible batting and poor catching by Guy's—mainly the latter. Of the bowlers, Pearson bowled intelligently and Watt-Smith had an erratic but effective spell when he took three valuable wickets.

Guy's: 176. (Swift, 71; Silk, 32.)
Wanderers: 121. (Watt-Smith, 3 for 21, Crafts, 2 for 18; Beacham, 2 for 27; Pearson, 2 for 43.)

M. I. APPLEBY

GUY'S v. HONOR OAK

At H.O.P. Saturday, 15th May, 1967

Result: lost by 6 wickets

Against local rivals Honor Oak, Guy's produced one of their poorest batting performances. In spite of accurate, attacking bowling by their battery of seam bowlers on a helpful pitch, too many wickets were lost to indifferent strokes; on the whole, the defensive strokes were played without authority and without the batsmen moving into the line of the ball. In addition, Honor Oak showed themselves to be a competent fielding side; no catches were dropped, and Butchey and Swift were out to very sharp chances.

Wilkinson, who has played for Kent, did most of the damage, taking six wickets for eight runs. Only Swift and Powell-Jackson, who defended bravely in his first innings of the season, put up much resistance.

When Honor Oak batted, the pitch had dried out, making batting conditions easier. Though Crafts, in a hostile spell, took two of the four wickets to fall. Honor Oak never looked in danger of defeat, and scored the 75 runs needed for victory at a run-a-minute.

Guy's: 74. (Wilkinson, 6 for 8.)
Honor Oak: 75 for 4. (Crafts, 2 for 24.)

M. I. APPLEBY

Hospitals' Cup—2nd Round
GUY'S v. WESTMINSTER HOSPITAL

Away Thursday, 18th May, 1967

Result: won by 5 wickets

Having received a bye in the First Round, Guy's opened their challenge for the Hospitals' Cup by defeating the Westminster Hospital in the Second Round by five wickets.

Due to traffic congestion in South London, Guy's took the field with only nine men; indeed, Silk was called upon to keep wicket, to which he reacted with unconcealed delight and unsuspected ability. After four overs, the Guy's complement was increased to the statutory 11, and Swift took his allotted place behind the stumps. The pitch was very slow, offering little encouragement to bowlers and little opportunity to batsmen for stroke-making. The opening pair batted cautiously without looking in much trouble; however, when their partnership had realised 48 runs, the persevering Crafts broke the stand, and this was the signal for a collapse to set in. Most of the damage was done by Clark and Davoodbhoy; the latter, in his first appearance of the season, showed that he had lost none of his considerable guile. Lunch was taken with the score at 74 for 7, and the innings was quickly polished off by D. Crafts and Davoodbhoy after the interval.

The Guy's innings had yet another bad start, both openers being bowled playing forward. Against some extremely accurate bowling, runs were hard to come by; Clark was beginning to bat with authority when he was out, and when Chase was caught from a tentative forward prod, the score had crept to a meagre 39 for 4 after 90 minutes batting. Silk and Swift, batting sensibly, then took the score to 57 before Silk chose the wrong ball for his hook and was bowled. The remaining runs were scored by Swift and Appleby, though not without alarm.

So Guy's have reached the Semi-final of the Cup where the holders, St. Thomas', will probably be awaiting us; after our defeat by them at the same stage last year, revenge would indeed be sweet.

Westminster Hospital: 84. (Davoodbhoy, 4 for 13; Clark, 4 for 24; D. Crafts, 2 for 19.)
Guy's: 85—5. (Silk, 25; Swift, 20 n.o.)

M. I. APPLEBY

GOLF

The Annual Match against the President's team was played at Tonbridge on Saturday, May 7th. It was a gloomy day, but the golf as usual started at 11 a.m.

The first eighteen holes were devoted to foursomes. The first match was decided on the last hole by the sinking of a 12-foot putt. The President's first pair scored a 79 gross. B. Bevan-Jones and A. J. Philips were four holes up with seven to play. Mr. Brain and Mr. Lewis-Lloyd still halved the match with some *remarkable golf, which included two 2's in the* last seven holes. Professor Cohen and the President beat N. Curry and V. G. Williams 4 and 2 by playing better all-round golf.

Play was resumed at 3.30 in the afternoon with six single matches. A. K. Symers was round in 71 beating P. Ellis by one hole in the top match. A. K. Symers was three up on the 11th but P. Ellis fought back to all-square on the 17th tee. V. G. Williams played very well to beat T. Tetlow by one hole. Mr. Lewis-Lloyd, playing his usual immaculate, steady golf, beat M. J. Brummit 5 and 4. B. Bevan-Jones played and putted well to beat Mr. Brain. On the eighth hole he holed a putt of some 20 feet. Professor Cohen started against A. J. Philips by doing the first six holes in one over par to find himself four holes in the lead. A. J. Philips never really got over the initial lead and was beaten 3 and 2. The President, Dr. Maclean, beat N. Curry 3 and 1 by playing much better golf under tension.

At the end of the day the President's team had beaten the Guy's team by the largest margin yet. Next year the Hospital club will have to prepare itself much better.

Result (President's team first)

Foursomes—

Mr. A. K. Symers and Mr. T. Tetlow beat P. Ellis and M. J. Brummitt, 1 hole.
Mr. R. Brain and Mr. Lewis-Lloyd halved with B. Bevan-Jones and A. J. Philips.
Professor Cohen and Dr. K. S. Maclean beat N. Curry and V G. Williams, 3 and 1.

Singles—

Mr. A. K. Symers beat P. Ellis (Captain), 1 hole.
Mr. T. Tetlow lost to V. G. Williams, 1 hole.
Mr. Lewis-Lloyd beat M. J. Brummitt, 5 and 4
Mr. R. Brain lost to B. Bevan-Jones 4 and 3.
Professor S. Cohen beat A. J. Philips, 3 and 2.
Dr. K. S. Maclean beat N. Curry, 3 and 1.

N.C

ATHLETICS

GUY'S v. ST. MARY'S

Result: lost, St. Mary's, 66; Guy's, 53

This match was held at H.O.P. on Wednesday, 10th May, 1967. There was a poor response from Guy's members. Although a few athletes were competing for the University team in Cambridge, more keenness from the rest of the team was expected. St. Mary's, who did not show much strength in the University Championships, managed to provide some fifteen members and were able to clinch a well deserved victory.

Unfortunately, D. Barford, still suffering from a thigh injury, was unable to do well in the sprints. In fact, the only Guy's member who asserted his strength was A. Ross who won both the shot and the discus. Mention must be made of T. Fallowfield and G. Harrild who won well-fought battles in the 440 yards and mile respectively. The rest of the afternoon was disappointing as evidenced by the results below:

100 yds.—T. Higgenbottom, 3rd; D. Barford, 4th.
220 yds.—S. Drage, 2nd, 24.4 sec.; T. Higgenbottom, 4th.
440 yds.—A. Fallowfield, 1st, 57.4 sces.; T. Higgenbottom, 3rd.
880 yds.—A. Fallowfield, 2nd, 2 mins. 11.0 secs.; G. Harrild, 3rd.
1 Mile—G. Harrild, 1st, 5 mins. 0 secs.
H. Jump—J. Domaingue, 2nd, 5ft. 4ins.; G. Harrild, 4th.
L. Jump—J. Domaingue, 2nd, 19ft. 10½ins.; G. Harrild, 4th.
T. Jump—J. Domaingue, 3rd, 39ft. 2ins.
Shot—A. Ross, 1st, 41ft. 8ins.; J. Stoneham, 3rd, 29ft. 11ins.
Discus—A. Ross, 1st, 109ft. 9ins.; J. Stoneham, 2nd, 84ft. 6ins.
Javelin—A. Ross, 2nd, 135ft. 9ins.; T. Higgenbottom, 4th.
4 x 110 yds. Relay—Guy's, 2nd.

J. DOMAINGUE
Capt. G.H.A.C.

Athletic Match
GUY'S v. GOLDSMITHS COLLEGE v. COLLEGE OF ESTATE MANAGEMENT

At H.O.P. Wednesday 17th May, 1967

Result: Goldsmiths, 100; C.E.M., 61 Guy's, 53

As the match against College of Estate Management, on Saturday, 13th May, had to be postponed, they joined us at Honor Oak Park in a match against Goldsmiths College.

The Guy's Club had very poor support for this match, but those who did compete covered every event except the high jump. Both opposition teams were well represented in all events; with better weather this would have been a very enjoyable competition.

Goldsmiths College gained 1st place in every event except the 440 yds. and javelin, they also gained four second places, and this combination gave them an easy win. For Guy's G. Voss was the busiest man of the afternoon, competing in the 100 yds., 220 yds., long jump, all the field events and the relays. It is good all-round ability like this which is so important in inter-college matches. S. Drage gained our only 1st place of the afternoon in the 440 yds. and finished a close second in the 220 yds. D. Barford—still recovering from a pulled muscle—entered the field events and 880 yds. T. Fallowfield ran consistently to second place in the 880 yds. and the mile and also joined the relay team.

This was a promising afternoon which was spoilt firstly by the weather and secondly by lack of support from the other members of the Club.

Results—

100 yds.—G. Voss, 3rd.
220 yds.—S. Drage, 2nd.; G. Voss, 5th.
440 yds.—S. Drage, 1st.
880 yds.—T. Fallowfield, 2nd; D. Barford, 4th.
1 Mile—T. Fallowfield, 2nd.
L. Jump—G. Voss, 5th.
Wt.—G. Voss, 2nd.; D. Barford, 3rd.
Discus—G. Voss, 3rd; D. Barford, 6th.
Javelin—G. Voss, 3rd.
Relay—Guy's, 3rd.

WATER POLO

HOSPITALS' KNOCK-OUT HANDICAP TOURNAMENT

16th May, 1967

Guy's II were unlucky to be drawn against London I in the first round. With a 3—1 handicap in their favour, their best hope was to prevent London from scoring, but this

proved too difficult and they went down 4—7 on aggregate.

Guy's I had a fairly easy first game against Westminster. Once the 1—3 deficit had been made up, Westminster could not really be a threat, and Guy's won by a few goals on aggregate. Barts, the semi-final opponents, were a bit more troublesome. The 1—2 deficit was soon changed to a 3—2 lead, but Bart's brought the scores back level before Guy's won, 5—3 on aggregate. In the other semi-final, Mary's I, the top seed, had a hard time in beating London I in a game which went to extra time, and must have been somewhat tired.

With a 1—0 handicap in Guy's favour, a quick goal was hoped for, which might give sufficient margin to hold onto by negative play. Sure enough, Challacombe scored with a fine long shot right at the beginning, which took Mary's by surprise. Unfortunately, it was not so easy to retain them by tightening the defence, and by half-time Mary's had scored two goals to bring the scores level. This looked very ominous as Mary's had the advantage of attacking the deep end. But Guy's held on well, with good goalkeeping by Wood, and came desperately close to victory at the end when Jones broke away, but he had to shoot from a difficult angle and somehow their goalkeeper blocked it. So the game went into extra-time. Almost immediately Mary's scored. But Challacombe replied with another well-taken goal, and Guy's once again found themselves at a half-time with level scores. Then it was a stroke of bad luck that put Guy's behind. A Guy's player took too long over a free throw, so Mary's were awarded a throw and they snapped up the opportunity to pass to a free player who scored. This time Guy's did not manage to strike back, and in fact it was Mary's who scored again to make the final aggregate score 5—3 to them.

Guy's I: Wood, Foulds (Capt.), Challacombe, Jones, Froom, Northcott.

Guy's II: Howard, Ashford (Capt.), Davidson, Aspin, Evans, Wright.

HOSPITAL INFORMATION

APPOINTMENTS VACANT

GUY'S HOSPITAL DENTAL SCHOOL

Applications are invited for appointments of **Temporary Demonstrator in the Department of Conservative Dental Surgery,** either full-time or with attendance on six, five, or three sessions per week, for the period 1st January to 30th June, 1968. Salary according to age, qualifications and experience. These temporary appointments are necessary because the new curriculum commences in October 1967, resulting in an increased number of students in the Department, particularly during this period. Forms of application are available from, and should be lodged with, the Dean, Guy's Hospital Dental School, London, S.E.1, as soon as possible.

HOUSE APPOINTMENTS

GUY'S HOSPITAL

June 1st, 1967

House Surgeons

Mr. Eckhoff	Mr. M. J. Light 3 *months*
Professor Atkins	Mr. R. J. Morgan 3 *months*
Mr. Wass	Mr. R. P. Juniper 6 *months*
Mr. Blackburn	Mr. A. P. Warin 3 *months*
Mr. Lawrie	Miss S. Haslewood 6 *months*
Mr. Glover	Mr. J. H. Topham 6 *months*
Mr. Brain	Mr. P. B. Ashcroft 3 *months*
Mr. Beard	Mr. R. H. S. Lane 6 *months*

House Physicians

Dr. Mann, Dr. Scott, and Dr. Bishop	Mr. A. Aynsley-Green 3 *months* Mr. K. Kermani 6 *months*
Dr. Hardwick, Professor Trounce and Dr. Deuchar	Miss D. C. Phillips 3 *months* Mr. P. M. Wood 6 *months*
Dr. Baker, Dr. Houston, and Dr. Grimble	Mr. R. K. Jacoby 3 *months* Mrs. C. A. Topham 6 *months*
Dr. Kauntze and Dr. Joiner	Mr. C. J. Davies 3 *months* Mr. D. S. Robins 6 *months*
Professor Butterfield and Dr. MacLean	Mr. J. V. Collins 3 *months* Miss H. Scott 6 *months*

House Surgeon to the Surgical Unit

Mr. D. P. G. Griffiths
6 *months*

Gynaecological House Surgeon

Miss A. de C. Evans
3 *months*

Throat and Ear House Surgeons

Miss R. A. Baker
3 *months*

Mr. N. C. Hamblyn
6 *months*

Orthopaedic House Surgeons

Mr N. A. Watson
3 *months*

Miss R. C. Radford
6 *months*

Genito-Urinary House Surgeon

Mr. D. F. H. Wardle
6 *months*

Children's House Physicians

Miss C. M. Holliday
3 *months*

Mr. R J. Leete
6 *months*

House Physician to Dr. Bishop, Dr. Wayte and Mr. McArthur

Mr. R. J. Eady
3 *months*

Casualty Officers
Mr. J. S. Gregson
3 *months*
Mr. J. R. Hockey
3 *months*
Mr. A. E. McKinnon
3 *months*
Mr. P. J. Metzner
3 *months*
Mr. J. M. Richards
6 *months*
Mr. J. F. Searle
6 *months*
Resident Obstetricians
Mr. A. W. J. Medhurst
3 *months*
Mr. D. L. Ingram
6 *months*
Neurological House Physician
Mr. R. A. Y. Pietroni
3 *months*
Dermatological House Physician
Mr. J. C. Robertson
3 *months*
House Physician in Child Psychiatry
Miss J. Heron
3 *months*
House Surgeons to the Thoracic Unit
Mr. T. H. Guerrier (S.H.O.)
3 *months*
Mr. A. J. M. Procter
6 *months*
House Physicians in Clinical Pathology
Mr. D. Leng
6 *months*
Mrs. A. Markanday
6 *months*
House Physicians in the Department of Psychological Medicine
Mr. S. Bhanji 1.6.67—30.9.67
Mr. B. H. Anstee 1.6.67—30.9.67
R.M.O.s in Nuffield House
Mr. A. J. Richards
3 *months*
Readvertised 1.7.67—31.12.67
Resident Anaesthetists
Mr. I. A. Sutherland
3 *months*
Mr. M. C. W. Morgan
3 *months*
Mrs. I. M. J. Mathias
6 *months*
Miss H. Hale
6 *months*
Children's House Physicians at the Evelina Hospital
Miss J. C. Summerscale 1.2.67—31. 7.67
Mr. B. C. O'Moore 1.4.67—30. 9.67
Vacant 1.6.67—30.11.67
Mr. C. L. Newman 1.8.67—31. 1.68
Casualty Officer at the Evelina Hospital
Mr. S. C. D. Mehta
3 *months*

ST. OLAVE'S HOSPITAL
House Physician to Dr. Mason and Dr. Cox:
Mr. P. Bowen-Simpkins
3 *months*
Mr. P. J. C. Trenchard
6 *months*
House Surgeon to Mr. O'Flynn:
Mr. S. C. A. Davoodbhoy
6 *months*
House Surgeon to Mr. Lewys Lloyd (S.H.O.):
Mr C. Bologna
6 *months*
House Physician to Dr. Cox (S.H.O.):
Mr. K. Sheth
4 *months*
Gynaecological House Surgeon (S.H.O.):
Miss S. E. Cox
3 *months*
Casualty Officer (S.H.O.):
Mr. J. C. Cochrane
Clinical Pathology (S.H.O.):
Miss P. Furnell 8.5.67—8.10.67

NEW CROSS HOSPITAL
House Physician in Medicine and Geriatrics (S.H.O.):
Mr. B. J. Mason
3 *months*
Mr. C. C. Penney
3 *months*
(S.H.O.):
Miss E. A. Cosgrove
6 *months*
Mr. D. A. Ryland
6 *months*
Orthopaedic House Surgeons:
(S.H.O.):
Mr. El Mariah
6 *months*
Mr. D. R. H. Vernon
6 *months*
S.H.O. to the Rehabilitation Unit:

LEWISHAM HOSPITAL
House Physician to Dr. Roberts:
Mr. B. W. Eliot
6 *months*
House Surgeon to Mr. Williams:
Miss C. Garrett
6 *months*

MILLER HOSPITAL
House Physicians to Dr. Lessof & Dr. Hartley:
Mr. T. Gibson (S.H.O.)
6 *months*
Mr. D. L. Beales
6 *months*
House Surgeon with E.N.T. & Ophthalmology:
Readvertised
House Surgeon with Orthopaedics & Gynaecology:
Mr. A. H. Osborne
6 *months*

ORPINGTON HOSPITAL
House Surgeon with Orthopaedics:
Readvertised
6 *months*

PEMBURY HOSPITAL
House Surgeon with Orthopaedics:
Readvertised
6 *months*
House Surgeon to Mr. Bell
Readvertised
6 *months*

ST. JOHN'S HOSPITAL, LEWISHAM
House Surgeon with Gynaecology:
Readvertised
6 *months*
House Surgeon with Gynaecology & Orthopaedics:
Mr. S. A. L. Ceesay
6 *months*

ST. NICHOLAS HOSPITAL
House Physician to Dr. Scott:
Mr. W. P. Onyeama
6 *months*

P. J. HELLIWELL,
Superintendent

May 10th, 1967

PASS LIST

UNIVERSITY OF OXFORD
2nd B.M. Examination
Special 2nd Clinical Pathology
H. W. Berry M. A. Coe

ROYAL COLLEGE OF PHYSICIANS OF LONDON
Elected to Fellowship
R. C. Coxon J. M. French
E. M. M. Besterman

PAPERS BY GUY'S MEN

Amiel, G. J. Conjoined entire twins. *Brit. J. clin. Pract.*, 1967, **21**, 141.

Amos, D. B. Comparison of the agglutination and cytotoxicity techniques used for the detection of human leukocyte isoantigens. *Ann. N.Y. Acad. Sci.*, 1966, **129**, 558.

Amos, D. B. Biological defense and recognition mechanisms. *Ann. N.Y. Acad. Sci.*, 1966, **129**, 750.

Anderson, K. Preparation of frozen poultry; prevention of staphylococcal food poisoning. *Med. J. Aust.*, 1966, **2**, 1223.

Batchelor, J. R. and Chapman, Beryl A. Absorption analyses of cytotoxic human isoantisera. *Ann. N.Y. Acad. Sci.*, 1966, **129**, 529.

Batty Shaw, A. Gall-bladder dyspepsia. *Practitioner*, 1967, **198**, 371.

Blaxter, P. L. and Britten, M. J. A. Transient amaurosis associated with sickle-cell trait. *Brit. med. J.*, 1967, **1**, 681.

Bowyer, A. and McColl, I. Investigation of pruritis ani and the role of erythrasma. *Brit. J. Surg.*, 1967, **54**, 235.

Brain, R. H. F. Place of jejunal transplantation in the treatment of simple strictures of the oesophagus. *Ann. Roy. Coll. Surg.*, 1967, **40**, 100.

Brittan, W. S. The Benevolent Fund. *Brit. dent. J.*, 1967, **122**, 271.

Brock, Lord. The good old days. *Ann. Roy. Coll. Surg.*, 1967, **40**, 194.

Campbell, M. and Deuchar, D. C. Absent inferior vena cava, symetrical liver, splenic agenesis, and situs inversus and their embryology. *Brit. Heart J.*, 1967, **29**, 268.

Cavenagh, J. B. Pattern of change in peripheral nerves produced by isoniazid intoxication in rats. *J. Neurol., Neurosurg. Psychiat.*, 1967, **30**, 26.

Ellis, F. G. and Lale, P. G. Measurement of muscle contraction by suction strain gauge. *Brit. J. Surg.*, 1967, **54**, 235.

Godden, L. J. British Dental Journal. *Brit. dent. J.*, 1967, **122**, 266.

Hardwick, C. Peptic ulcer problem. *Practitioner*, 1967, **198**, 345.

Hayward, J. L. and another. Abnormal urinary steroid excretion and subsequent breast cancer. *Lancet*, 1967, **1**, 419.

Hellewell, J. and Potts, M. W. Home on a ventilator. *Practitioner*, 1967, **198**, 408.

Kendall, P. H. and Cahill, W. J. Control of morning stiffness in rheumatoid arthritis by high salicylate dosage—a preliminary report. *Ann. phys. Med.*, 1967, **9**, 19.

Lane, R. E. and others. Effects of histamine aerosol in byssinotic subjects. *Brit. J. indust. Med.*, 1967, **24**, 38.

Lascelles, R. G. A typical facial pain and depression. *Brit. J. Psychiat.*, 1966, **112**, 651.

McColl, I., Andrews, D., Gazet, J. C., Raven, J. L. and Streek, S. Effect of intrinsic factor on absorption of vitamin B_{12} from small intestine. *Lancet*, 1967, **1**, 544.

Macdonald, I. Dietary carbohydrates in normolipemia. *Amer. J. clin. Nut.*, 1967, **20**, 185.

Mackenzie, I. C. K. Narcolepsy and cataplexy. *Practitioner*, 1967, **198**, 520.

Oliver, G. C., Gazetopoulos, N. and Deuchar, D. C. Reversed mitral diastolic gradient in aortic incompetence. *Brit. Heart J.*, 1967, **29**, 239.

Parks, A. G. and Fishlock, D. J. Studies with drugs and hormones on the human colon: catecholamines. *Proc. R. Soc. Med.*, 1967, **60**, 217.

Pryse-Phillips, W. E. M. Bowler's cramp. *Med. J. Aust.*, 1967, **1** 61.

Ross, D. N. and others. Early jaundice after open heart surgery. *Thorax*, 1967, **22**, 165.

Symonds, Sir Charles. Disorders of memory. *Brain*, 1966, **89**, 625.

Tothill, Anne. Motor effect of adrenaline on the rat uterus. *Nature*, 1967, **213**, 1230.

Wigginston, D J. Dentists' Provident Society. *Brit. dent. J.*, 1967, **122**, 272.

Zilkha, K. J. Migraine clinics. *Practitioner*, 1967, **198**, 495.

PERSONAL

ANGLIA d/1 Nov., 1962—For sale. Only 2 owners 50,000 miles. In excellent condition Radio. £245 o.n.o. Contact Robins, East Wing, Guy's Hospital, S.E.1

ASSOCIATE, ASSISTANT OR LOCUM wanted in Multiple Dental Practice West Sussex. Excellent staff, conditions and equipment. Complete clinical freedom. Small flat. Box No. 27/5

GETTING MARRIED?—New unfurnished flat in Wallington for Dental Assistant. Own nameplate, telephone and E. C. Numbers. Write 3 Hillcroft Avenue, Purley, Surrey.

SAN FRANCISCO/LONDON ACCOMMODATION EXCHANGE. American Professor on a Fulbright Fellowship to Guy's wishes to exchange four-bedroomed, two reception-roomed ranch-style house overlooking Bay and Bay Bridge for a two or three-bedroomed house or flat within easy access to Guy's. September, 1967—June, 1968. Professor Merril, Director Communications Office for Research and Teaching, University of California, San Francisco, California 94122, U.S.A.

TO LET—Delightful holiday cottages, near Corwen, Merionethshire. Sleep five and six. Willcock, Colnet House, Roseway, Shrewsbury. Tel. Shrewsbury 3018.

CHANGES OF ADDRESS

Dr. J. D. Grene, Little Brome, 33, Bridge End, Warwick.

Mr. J. O. Ojukwu, M.Chir., F.R.C.S., Department of Surgery, University of Nigeria Teaching Hospital, Enugu, Eastern Nigeria.

Mr. H. Gordon Ryder, L.D.S., R.C.S., Wharema Home, Neale Avenue, Stoke, Nelson, New Zealand.

BIRTHS

CUMMING—On 28th April, at Wantage Hospital, to Roger and June, a daughter, Victoria

JEMSON—On 18th March, 1966, to Barbara (née Duke, S.R.N.) and John Jemson, M.B., B.S., L.M.C.C., in Glenboro, Manitoba, a daughter, Lucinda, sister for James, Steven, Paul and Elizabeth.

NORTON—On March, 3rd, 1967, at Woolwich Memorial Hospital, to June (née Brett) and John Norton, a daughter, Anne Elizabeth.

We would like to remind our readers that all copy for inclusion in the Gazette must be received eight days before the publication date.

Personal notices one shilling per word (Minimum £1. 1s. 0d.)
Birth, Marriage, Death and Change of Address notices are without charge to subscribers.
Non-subscribers will pay £1. 1s. 0d. for all notices other than Personal.

GUY'S HOSPITAL GAZETTE

EDITORS D. S. ROBINS and C. B. BROWN
SPORTS CORRESPONDENT J. G. PAYNE
NURSING CORRESPONDENT E. A. MALPAS

FORTNIGHTLY TWO SHILLINGS VOLUME 81 NUMBER 2058

The opinions expressed in these columns are solely those of their authors and are not to be taken as the views of the Hospital as a whole.

PASSIM

The Prize

In its pursuance of what is basically a modified form of clinical apprenticeship, Guy's has much for which it can be praised. That it continues to do so in spite of the many students who do not avail themselves of the many and varied facilities which exist for their education is also praiseworthy. The principle: do not scrap a system because it is not properly used.

The majority of students enter straight from school, find their first few years as undergraduates similar in educational form to school, with fixed comprehensive (in terms of syllabus) courses of lectures and terminal exams. It is not surprising that the majority are not fitted for rapid or even relatively rapid orientation to a system which suddenly throws most of the onus for educational progress onto the spoon-fed student's initiative or conscience. For reasons largely independent of their early London University experience and/or, dare we say it, often due to experience of another hospital, the small number who have the ability to take this change in their stride fortunately increases, but very slowly. It is correspondingly not surprising that the call has come from some quarters for a form of periodic examination during the three years of clinical training. All too often it is only the Lucifer of Finals that brings attention back fully to the career at hand, by which time two years at least have passed with rather a poor return in terms of medical educational effort.

Intentionally or not, the availability of internal prize examinations are potentially an effort to help the student to keep on his studying toes. The snag is that by their very name these examinations tend to attract the effort mainly of those who are least in need of this study incentive. Being also by their nature voluntary, they fail on the whole to fulfil the large and sorry necessity of the postulated educational whip of general periodic examinations. We hear of the debates, furtive meetings and the establishment of camps of dichotomous

educational ideas for the preclinical education, both in itself and in its relationship to the clinical period, but so much less on the improvement for the latter.

Again on the principle of retaining the good though ill-used system, we fully support the preservation and growth of prize examinations, but ask that they are used more actively as educational aids by their administrators. This would involve considerably more active encouragement to take the exams and better advertisement of their presence and times than the notice on the unread notice-board or the paragraph in the Calendar or Prospectus which sits at the back of some forgotten bottom drawer. It is a sorry truth that for the majority of students, here at least, it is still necessary for the educational cake to be placed on a glittering plate before it is eaten.

Postscript: With some pleasure we notice the recent award of a new prize given to a final year medical student who is judged to be most proficient in the care of his patients. We look forward to the establishment of further similar prizes being awarded along the truism that a good medical student is more than one who has only all the small textbook print at the tip of his tongue, or as is commonly seen, at that of his examination pen.

An Individual Stand

In the last two weeks, two dissimilar acts of human endurange were performed. One where a man pitted himself against the forces of Nature, and the other where he pitted himself against the forces of Man. The former is Francis Chichester, the latter Howard Brett Levy.

The saga of Francis Chichester's single-handed round-the-world sail needs no telling; it has been adequately covered in the Press and on television. But that of Dr. Levy is practically unknown.

Dr. Levy was, until last week, a Captain in the U.S. Army in the Department of Dermatology at the Fort Jackson Military Hospital, South Carolina.

Physicians are brought into service in wholesal lots, with few of the opportunities for deferment open to other young men. The long period of pre-medical and medical training is extended by the military obligation.

Once in uniform, many doctors find it difficult to comprehend the petty irrelevancies, and the arbitrariness of military routine. Some harbour deeper doubts about their role in an agency of destruction, and all have to unlearn many of the values which they have learned during their medical training.

Captain Levy's job was to train Special Forces Aidmen—the para-medical troops in the "Green Berets"—for duty in Vietnam. The Aidmen are required to use their training for the survival of their own small patrols, for the health of the 1,500 or more "counter-

insurgents" in their camps, and for the benefit of whatever civilian Vietnamese that come their way. But the policy they serve is the U.S. mission in Vietnam and the Aidmen are ultimately guided by the military and political demands of that mission.

It may be considered that the para-medical programme violates traditional principles of medical ethics, and leading scientists and physicians such as Jean Mayer and Victor Sidel of Harvard, and Louis Lasagna of Johns Hopkins have gone to Fort Jackson to tell just how that is so.

Dr. Levy was not expected to train them very thoroughly, just a few points in the diagnosis and treatment of skin disease were required. But as time passed he thought harder about the war and his relation to it, and found it harder to bring himself to go on.

Then last summer, Dr. Levy stopped training the Green Berets.

At length, Dr. Levy's activities reached the Commanding Officer, who considered disciplinary action. Dr. Levy's security file contained what was considered damning information. He had once attended a series of lectures by Negro radicals sponsored by a Trotskyist faction in New York; he had engaged in civil rights activities, helped in a welfare workers' strike, and was known to have leftist views.

Dr. Levy was committed to a court martial, accused of refusing to obey the order to train Aidmen, of promoting "disaffection and disloyalty", and "conduct unbecoming an officer and a gentleman". Levy faced 11 years in prison if convicted. He was defended by the American Civil Liberties Union and last week was sentenced to three years' imprisonment.

The case presents the agonising problem of a man's responsibility for his own acts. In addition, medical ethics has become a major issue because of its possibilities for legal defence.

But the crux of the matter is whether men can pass off their moral obligations onto the institutions they serve, or into whose service they are pressed. That was the Nuremburg question, the Eichmann question.

Waiting Comfortably

While we patiently wait for the future building worthy of this hospital, we content ourselves with patching up our crumbling old ones. We touch a bit of paint here, install a new lift there, and exercise our ingenuity in re-interior decoration. The most recent and colourful product is the out-patients department. The policy is an exercise in pure psychology: it makes the long wait suddenly an attraction, and little matters what the consultation and examination facilities are like. An even purer form is the current work going on in the section of the newly-acquired buildings on the north side of St. Thomas' Street for the home of the Tower Block Planning Committee. The wait may or may not be long, may or may not be patient, but at least it will be comfortable.

The British Diabetic Association are seeking help for the holiday camps run by the Association for Diabetic Children, and not unexpectedly are looking for such help amongst medical students. Six camps in all are being arranged, mostly of a fortnight's duration, and include sites in Northern Ireland and Scotland. To the students who volunteer for this worthy cause, fares and a small honorarium will be paid, but they will no doubt obtain far more than that.

Further details from the Medical School Office.

We offer our congratulations to Mr. and Mrs. A. Baker, of 12, Cambridge Gardens, Tunbridge Wells, Kent, on the occasion of their Diamond Wedding Anniversary on the 7th June. Mr. Baker is in his 67th year at Guy's, in the Physiology Department.

We offer our congratulations to Mr. G. C. W. Baker on his appointment as Consultant Orthopaedic Surgeon to the Chesterfield Group of Hospitals, Derbyshire.

ERRATA: Quizette G.H.G. 27.5.67:

Ques. 5 " . . . upper arm and **thigh** muscles"
Ans. 7 " . . . occurs most often in a **familial** . . . "

GUY'S DIARY

JUNE			EXHIBITION : In the Gordon Museum.
13th	Tu.	1.00	"Haematuria." Clinical Lecture. Mr. ECKHOFF. "What is Plastic Surgery?"
		5.00	Medical Genetics series: In the Physiology Theatre. Dr. J. FRASER ROBERTS. "Genetic Counselling I."
15th	Th.	1.00	Clinical Lecture. Mr. WASS. "Swellings of the Thyroid Gland."
		5.00	Neurosurgical Round. In the Clinical Theatre. Mr. P. SCHUUR.
16th	F.	2.15	Combined Round. In the Pre-clinical Classroom. Prof. ADAMS. "Atheroma."
19th	M.	1.00	Clinical Lecture. Dr. FAWCUS. "Voice without a Larynx."
20th	Tu.	1.00	Clinical Lecture. Dr. BISHOP. "The Management of Subfertility."
		5.00	Medical Genetics Series: In the Physiology Theatre. Dr. J. FRASER ROBERTS. "Genetic Counselling II."
22nd	Th.	1.00	Clinical Lecture. Prof. A. BRUNSCHWIG, M.D., (Professor of Surgery, Memorial Hospital, New York). "Studies in Human Physiology incident to Radical Surgery for Cancer."
23rd	F.	1.00	Clinical Lecture. Prof. BUTTERFIELD.
		2.15	Combined Round. In the Pre-clinical Classroom. Dr. Mann.

PLAY

in Relation to the Development of Babies and Young Children

by DOROTHY F. EGAN

"Play is the serious work of the young child, the most important business of his waking hours."

The physical, mental and emotional development of the child, from the earliest moment after birth, progresses in four parallel and closely interwoven fields; locomotion and posture; vision and hand and eye co-ordination; hearing and speech, and social communication. Play is the exercise of the child's growing powers in these fields.

Learning of skills is dependent on maturation in the central nervous system. No amount of encouragement, for example, would make a baby of three months crawl, for he is not yet ready to learn. But when he is ready for a new skill, he will show a curiosity and drive to achieve which is not triggered off solely by his organic needs. He will try and feed himself with a spoon in spite of much difficulty in filling it. At first, he invariably turns it upside down on the way to his mouth, thus his immediate intake of food is inevitably lessened, but he still goes on trying. As soon as one skill has been achieved, the child at once makes it harder for himself. When he has taken his first steps in walking he will walk most of the time, although he could get about the room more rapidly by crawling. We recognise in the baby and young child a progressive demand for new achievements and a continuing appraisal of his own effectiveness in relation to his environment.

Certain factors will influence the way in which the child develops, and the rate at which he does so:—

(a) hereditary make-up and inborn characteristics;
(b) the opportunity to learn, stimulation and experience;
(c) emotional security, and encouragement and approval by the adult.

Birth to Six Months

Play of the very young baby is almost wholly concerned with social communication and by six weeks of age he will respond to friendly advances by smiling. His attention, however, is restricted in space and time to mother-child distance. It is not until the child has reached three years of age that rapport can be maintained at a distance of 10 feet. This does not mean that he cannot see and hear at greater distances, but his visual and auditory attention are limited.

The beginnings of purposeful play are not seen until about 12 weeks when the baby brings his hands together over his chest in the middle line. He watches his hand and his eyes converge as he gazes at his moving fingers—for stereoscopic vision has now come

in. He will hold a rattle if it is put into his hand and will look at it and wave it, often hitting himself on the head with it, but he is unable to put it down or find it for himself.

He becomes intensely pre-occupied with the human face at 18 weeks and it is often quite difficult to detach oneself from his intense gaze. Screening tests are often very difficult at this age because in the intensity of his regard of the examiner's face the baby ignores all other stimuli. At about six months of age the baby waves his legs up in the vertical, often grasping one ankle with his hand. This action precedes his ability to sit up unsupported. His hand and eye co-ordination are now sufficiently advanced for him to reach out and grasp a block or toy and to palm it into his hand. He is normally very active, reaching for everything and taking it to his mouth. He has little interest in teddy-bears or other soft toys, which his kind aunts so often bring him, but likes to play with wooden blocks, threaded wooden beads, plastic cups and wooden spoons.

Six to Twelve Months

The child's ability to manipulate now increases rapidly. He learns to pass toys from hand to hand and to hold a wooden block

Nine months—Taking out peg men with superior pincer grasp.

in each hand. In a few more weeks, he will begin to understand the permanence of objects, thus he will look for a toy that falls to the ground. He loves the sensation of holding wooden blocks and banging them together, or sliding them about on the table. He has learnt to perceive welcome situations, realising in advance when he is going to be picked up or recognising that the dinner bowl is on the way. By ten months he can throw his toys out of the pram and will watch them as they roll away. If a willing adult will pick them up this game is endless! He can sit indefinitely on the floor with his toys around him and can crawl towards objects which catch his eye. He soon learns to pull himself up by the side of a chair and may crow triumphantly when he achieves this for the first time. At this age, he enjoys putting toys into a box and taking them out again. This will engross him for long periods. He vocalises eagerly, babbling in strings and sometimes crowing with pleasure as he listens to his own vocalisations. He can imitate "pat-a-cake" and will repeat this game delightedly if encouraged by adult approval. "Peep-bo" is another favourite game.

The baby now begins to be aware of strangers, and may hide his head in his mother's shoulder or burst into tears when approaches are made to him by people he does not know. This is not, as his mother so often thinks, regression or failure but a sign of maturity at this age. He can wave "bye-bye" on request, and may gladly do so as he leaves the consulting room, thus giving the doctor the only positive example of his powers of communication.

Twelve to Eighteen Months

The child constantly explores the world around him, cruising round the furniture or toddling from room to room, looking into drawers and cupboards, pulling the contents on to the floor, which quickly becomes strewn from end to end. Only rarely will he replace one or two objects. He will discard any toy, the moment his interest in it ceases, often casting it over his head without a backward glance. He may walk on it with equal disregard whether it be a favourite teddy or a more solid toy. This pattern of behaviour may persist to three or four years of age in severely mentally retarded children in whom, of course, it is a sign of immaturity. At fourteen to fifteen months, he loves to make a noise and enjoys a hammer toy, which not only develops his hand and eye co-ordination but gives at the same time a very satisfactory bang. This is the age for pull and push toys, and he learns to steer with increasing skill. He will then load up the truck with a heap of toys or will make it harder for himself by pulling the truck with another child in it. His manipulation of wooden peg-men has now improved and he can put in as skilfully as earlier he could take out. He likes to sit on his mother's knee to look at picture books, particularly those with brightly coloured pictures of familiar, everyday objects. This is excellent language training. He turns several pages together, but by the time he is two years old he will turn a single page with delicate precision. He speaks in single words or makes an early attempt at a phrase such as

"Hiya" for "here you are", but he understands many more words than he can say. He will give "car", "spoon" or "ball" on request, or will show that he knows where his shoes are by looking down or raising his foot. He defines objects by action—when given a brush, he will brush his own hair—later he will brush an adult's hair. He may finish the last line of a nursery rhyme or the last word in a sentence of his prayers.

By eighteen months he is generally walking securely about the room and he will squat characteristically at this age to play with his toys on the floor. His social contacts with other children are transitory and happen by chance. He will push other children out of his way or take what he wants from them in an entirely impersonal fashion. He is very dependent on the adult and needs encouragement to reinforce his achievements, and frequently looks for approval. Between the age of eighteen months and two years, he is unlikely to amuse himself for long with his toys, unless he has a sympathetic adult nearby to whom he can refer. This dependence on the adult is very well shown by little girls' play with the dolls' house. The child will take small toys from the dolls' house and carry them to her mother's lap, returning from time to time for more.

Two to Three Years

At two years of age, the child has learned to imitate adult behaviour and boys and girls love to do domestic chores with mother or father; to try to dress and undress themselves and to wash their faces and hands. If one observes their play, however, one sees that dolls and teddies do not as yet represent baby. The action of putting the doll or teddy to bed may be imitated, but the two-year-old, suddenly becoming dissatisfied with the arrangement of covers,

Two and a half years—beginning of imaginative play.

may drop the doll to the ground, possibly stepping on it, while re-arranging the blankets to her better satisfaction.

By two-and-a-half, however, children can symbolise in their play the meaning they have found in the world around them. Domestic play is initiated by themselves. Dolls are treated tenderly and tea-parties and playing houses become favourite games. This is the beginning of imaginative play. At this age, children are beginning to talk in sentences and should have a continuous opportunity to listen to speech, especially that of adults. They can describe pictures as well as name them, and love to scribble with a pencil or to paint in a single colour all over a sheet of paper.

Three to Four Years

The three-year-old loves to socialise with other children of his own age, but plays largely *by* them not *with* them. A differentiation of interest in toys and games as between boys and girls begins to show itself. Boys tend to like trains and motor cars, and will crawl endlessly round the floor pushing them to and fro—the clockwork or electric variety are strictly for fathers. No three-year-old will permit his train to be wound up. Girls, on the other hand, like tea-sets, dolls and more domestic play.

At this age, too, children begin to share, and will soon accept the frustration of taking turns. Three-year-olds, however, remain largely detached in any emergency situation in which other children are snatching from each other or fighting, whereas four-year-olds will immediately either run to fetch an adult or deal with the situation himself. They love to listen to nursery rhymes and stories and musical games are enjoyed by boys and girls alike. They can draw and paint a man, progressing later to a house, always with a large, round, yellow sun sending out its rays over the roof.

Four and Five Years

A four-year-old needs the company of his peers. His sense of justice has developed and is expressed in his "I had it first", which is reason and justification for his remaining in possession of the desired toy. The four-year-old can play alone without the adult at hand and becomes increasingly skilful with constructional toys, and in cutting out and making patterns. Competitive games begin to be of interest, such as dominoes and "happy families", although the four-year-old will still find it difficult not to win every time. All communication has vastly improved and can be expressed in representation in painting and drawing, and in the creation of trains, buses and houses out of an odd assortment of junk material in individual and group play.

The exercise of the child's growing powers has been shown to progress from the smiling response of the young baby to increased skill in manipulation, exploration, imitation and finally to imaginative and creative play.

"The child's play is the infantile form of the human ability to deal with experience by created model situations and to master reality by experience and planning."

THE ROMANS WERE HERE

—Archaeological Evidence from Guy's

Angela I. Taylor

The most satisfactory archaeological evidence is that derived from scientific excavation but where such excavation is impossible the field archaeologist must glean evidence from building sites and holes in the road. The trenches in the park at Guy's have been watched for archaeological material and a surprising wealth of this has emerged.

The earliest find to date is a single sherd of crude Iron Age pottery of 1st C A.D. date. This is parallelled by similar very sparse finds from other Southwark excavations and probably represents the native element contemporary with Roman Southwark. The Roman evidence from Guy's comes from three sources. The first is the "legend" of the Roman villa located when the Nurses' Home was built. Finds included a complete amphora now in private hands. When New Guy's House was built a Roman boat was located in the silted-up channel which formerly led to the Thames. Muller[1] directed an excavation in 1965 which re-located the boat, and two fragments of red polished Samian pottery were also found.

The spoil from the excavations in the park and routine examinations of flower beds have yielded a good deal of Roman material, including roof and floor tiles, tesserae, daub and painted wall plaster. These finds indicate a substantial Roman building. A variety of pottery included Samian wares and a selection of coarse pottery, much of it with gritty fabric. There were two sherds of British imitation Samian—the so-called colour coated ware. In date this pottery spans 1st—4th centuries A.D. One particularly distinctive sherd of moulded Samian ware is Dragendorf form 37, from one of the Trajanic potters of central Gaul, c. A.D. 100-120. A similar sherd came from a Walbrook site in the City of London (Merrifield[2]).

Unfortunately, owing to the tunnels and sewers, whe have no stratified Roman material as yet. Kenyon[3] dug five Southwark sites in the 1940s; of these King's Head Yard is especially relevant as it may represent the same group of buildings as our material. She found evidence for a Roman building built c. A.D. 180. There also appears to have been a contemporary settlement at the south end of Roman London Bridge (Beeby[4]).

After the 4th century, Kenyon found no evidence of occupation until c. 1300 and our evidence supports this in a complete lack of Saxon material. We have part of a glazed mediaeval tile and a few sherds. There are a few green-glazed Tudor sherds.

During the seventeenth century a huge plague pit is alleged to have covered much of the area of Guy's. Human skeletal material certainly supports this but there is also a great deal of domestic refuse which predates the foundation of the Hospital in 1725. Documentary evidence suggests that the first Southwark tin-glaze potter was established in 1625. From this date onwards a chain of potteries grew up on the south bank as the potters were aliens and were not allowed to work in the City. We have a great variety of tin-glazed ware (Delftware) much of it rough and probably locally made.

There is also a great range of brown and yellow lead-glazed wares of 17th—18th century date, some locally made, some from Norwich and Staffordshire. Imports include Rhenish stonewares and Chinese porcelain. There is a complete series of clay tobacco pipes from 1650—1800.

The finds are on display in the Gordon Museum, by kind permission of the Curator.

REFERENCES
(1) Maitland Muller, M. E., unpublished work, 1965.
(2) Merrifield, Ralph, personal communication, 1967.
(3) Kenyon, K. M., Excavations in Southwark, 1945-1947.
(4) Beeby, B., Quoted in *Daily Telegraph,* 22.5.67.

NOTICES

Guy's Hospital Archaeological Society

Are you interested in the history of Guy's? A collection of pottery and tiles and other material from the excavations in the park indicates Iron Age, Roman and mediaeval occupations of the site as well as the early phase of the Hospital. If you would like to inspect. learn about and possibly help collect this sort of evidence, join this newly-formed Society. We hope to do practical work, research on early maps and records and have lecture-discussions on aspects of archaeology. We will probably begin with a talk on Roman London.

Will anyone interested please contact Dr. Angela Taylor in the Paediatric Research Unit (484).

Past v. Present

The Annual Past v. Present Cricket match is to be played at H.O.P. on Saturday, June 24th, 2.00 p.m. start. Would anyone who would like to play for the Past please contact A. J. M. Procter, c/o East Wing, Guy's Hospital.

Boat Club A.G.M.

The Annual General Meeting of the Boat Club will be held at 12.15 in the Committee Room of the East Wing on June 7th.

90 Years Ago

From "Hints for Surgical Ward Clerks" June, 1877

. . . To detect sugar (in urine), boil a small quantity of Dr. Pavy's solution (Lig Pavii) in a test tube, and then gradually add about an equal quantity of the suspected urine. If sugar be present, a precipitate of a deep reddish-yellow colour will be found.

Ibid June, 1877

. . . With regard to the use of the clinical thermometer, but little would seem necessary, although I have seen a reporter taking temperatures with the bulb of the instrument uppermost, and another quietly setting down the abnormally low temperatures indicated to him by the inferior extremity of his index.

50 Years Ago

From Passim June 2nd, 1917

Treatment of venereal disease is compulsory in the Army, and it is but a further step to extend this to those who supply the Army, which means at present practically the whole country.

From Passim June 2nd, 1917

The following letter has been received by the Dean of the Medical School:—"Dear Sir,—I have now to inform you that the Royal Colleges of Physicians and Surgeons have decided not to enforce, for the present, attendances on systematic courses of lectures on the following subjects, namely: Anatomy, Physiology, Medicine, Surgery, Midwifery, Pathology, Pharmacology and Therapeutics, Forensic Medicine, including Insanity, and Public Health. I am, dear Sir, yours faithfully, Frederic G. Hallett, Secretary."

From Passim June 16th, 1917

A well-known consulting physician, when asked by Sir Alfred Keogh his opinion on the R.A.M.C., is reported to have replied that he supposed the organization was very fine, but as far as he could see most of the doctors were in France and most of the patients in England, and in consequence they did not meet very often.

From Passim June 16th, 1917

Considerable anxiety, and in some cases indignation, is being caused by rumours that part of the "Park" is to be sacrificed and destroyed in order that incompetent motor-drivers may have more scope for their evolutions outside Hunt's House. These rumours are, we fear, confirmed by the appearance of a maze of white-washed lines which presumably mark the course of the new circular tracks. If what appears to be the plan adopted is carried out nearly 2,000 square feet of the best grass under the trees will be destroyed, and the amenities of the "Park" seriously interfered with.

From Passim June 16th, 1917

Many of the younger generation at Guy's may not realize how much the Re-Endowment Fund has done for the Hospital. But for the big effort of 1896 many of our wards might have been closed, with disastrous results for the rapidly increasing population of the Boro' and for the Medical School . . . Further, many of the Funds to provide lectureships and Prizes owe their origin to the revival of interest in the Hospital which began at the Banquet in 1896.

THE MEDICAL PROTECTION SOCIETY

FOUNDED 1892

MEMBERSHIP EXCEEDS 45000

Membership secures protection of professional interests by a personal advisory service and the provision of unlimited indemnity against legal costs and damages.

Apply:—

THE MEDICAL PROTECTION SOCIETY
50 HALLAM STREET · LONDON · W.1
Telephone LANGHAM 9241

Senior Medical Secretary
Herbert Constable
MRCS, LRCP

Dental Secretary
Frank Allott,
LDS

CORRESPONDENCE

Great Maze Pond Closes

SIR,—In my letter of the 13th February I gave provisional dates for the major sections of the works preparatory to the Tower Block. The closing of Great Maze Pond was scheduled for the 19th June, but this will now be advanced to the 16th June. The section of Great Maze Pond from the Hospital Gate to St. Thomas's Street, will be closed to all vehicles from 8 p.m. on that day. This is to allow for the laying of a new main sewer in the road and the re-routing of electricity, gas and telephone services.

The main entrance for vehicles to the Hospital will then be from Snowsfields by the Out-Patients Department. Exit from the Hospital will be by the road running in front of New Guy's House and out into Weston Street. At all times a public footpath has to be maintained along the whole length of Great Maze Pond so pedestrians will not be affected by these temporary arrangements.

It is expected that Great Maze Pond will be re-opened to Hospital traffic by the end of this year.

Yours, etc.,

A. H. BURFOOT,
Clerk to the Governors.

Counting House,
Guy's Hospital,
London, S.E.1.

No Tariffs

SIR,—With regard to the subject of differential fees for home and overseas students, I can hardly express my own opinion more adequately than by quoting the enclosed from the annual report of the Principal of the University of London (1967).

"While universities are strongly of the opinion that differential fees for home and overseas students should not be a permanent feature of the university scene, we have in fact given way temporarily and we therefore start the long argument to remove the differential under a severe handicap. We shall win only if we can so arrange the discussions that everyone taking part realises that there is an important question of academic principle involved and that the financial problem of limiting subsidies to overseas students is capable of other solutions than the one chosen by the Government. No self-respecting university, if left to its own devices, would try to bridge the gap between expenditure and income by charging differential fees to overseas students. It should be remembered that universities, though inevitably situated within national boundaries, have from earliest days recognised that they also have an international function which they have discharged by adopting an 'open door' policy towards overseas students. By so doing, they have enriched their own intellectual lives and played their part in the promotion of international understanding. As Lord Macmillan, once Chairman of the Court of this University, reminded an audience at a time when this country's economic problems were very similar to those which face us today:

> 'Commerce and especially international commerce in the things of the mind and spirit is even more important. Our best export consists of the ideas of freedom, tolerance and good government of which so large a part of the world stands sorely in need . . . The commerce of ideas unlike the commerce of commodities can never be embarrassed by over-production or by under-consumption and the rates of exchange are always in favour of both exporter and importer.'

Like him, I am a confirmed free-trader and completely opposed to the imposition of tariffs in this field."

Yours, etc.,

J. JOSEPH

Anatomy Department,
Guy's Hospital Medical School,
London Bridge, S.E.1.

" . . . of course discipline is a dirty word."

Gazette, May 13, 1967, page 258.

SIR,—To the dirty all things are dirty. But wise discipline which leads to self-discipline is the tap-root of our lives. Without it one becames rudderless, the sport of the winds of emotion and self-interest.

With our roots grounded in self-discipline we all can become the master of our fate, the captain of our soul. And we have a soul, whether we like it and recognise it or not.

As Kipling's Tomkinson was told, both by St. Peter, who blocked his way, and the Devil, who rejected him " . . . the race is run by one and one and never by two and two . . . the sin ye do by two and two, ye must pay for one by one."

Discipline is a good word and sex is a good ward, an attribute given to us by God, but it must have a master.

And God, too, whether one likes Him or not, is still God—in all forms of religion throughout the world.

Yours, etc.,

E. P. MacManus

Terrybaron,
Babeenaun,
Balluia, Co. Mayo.

Let's Go With . . .

SIR,—I have followed closely the correspondence resulting from the publication of the Passim "Sex is here to Stay". Recent letters, however, seem to be dealing with much wider issues than those raised in the original editorial. David Boulton's letter is essentially an attack on the Christian ethic and I would be grateful for the opportunity to comment.

Boulton's argument seems to be that there have been standards of morality for two thousand years, which have not resulted in us becoming increasingly chaste, producing fewer illegitimate children, and committing less adultery. "Christian sexual morality," he asserts, "does not fit the facts of society. It fails to prevent what it views as certain types of undesirable sexual activity . . . " He sees the solution in us coming "to terms with what we are, instead of theorising on what we ought to be . . . "

Certainly one would agree with Boulton that the adherence simply to a moral code will not be the answer. It cannot by its nature prevent men from falling short of the "Standard". Yet this whole argument seems to be largely the old one, "You can't change human nature—so why bother?" At the same time the Christian would be the first to agree with him that we ought to "come to terms with what we are". But surely what matters most is not so much what we are, as what we may become.

So often the cry "You can't change human nature" conceals the thought that we do not very much want human nature changed anyhow. We prefer to enjoy the liberties and pleasure we can take, for as long as possible—without contemplating the consequences. But when some tragedy overtakes us, or a life gets spoilt, or relationships go rotten just when they seemed to be ripening, we are suddenly brought to a stop—perhaps for the first time seeing the reality of things as they really are.

It is at times like these, that we need to be reminded that it is quite untrue that human nature cannot be changed, for that is precisely why God came Himself to our world as Jesus Christ. Jesus Christ did not come to emphasize prohibitions, let alone to enforce them, but to afford power to men and women to live as He intended and in a way they would find deeply satisfying.

In contrast to Boulton, I believe that Christian sexual morality *does* fit the facts of Society. For it is only when real love binds partners—the kind where each looks for the highest good of the other—that a relationship will ever be truly successful and satisfying and more than just a tie of social convenience. Mere passion or inclination is no sound basis for a relationship. (Other correspondents have given evidence for the fact that promiscuity does affect society and the individuals who practise it.) More importantly, true Christians, surprising as it may seem, do not have to rely only on their own powers of discipline and control to maintain the highest standards in a relationship. God's power is with

them. The only "casualties" of Christian sexual morality are those attempting to "go it alone".

Finally, I agree wholeheartedly with Boulton that we should be "ashamed of the way in which the unmarried mother and child are received into Society". Christians continue to play their part against the "rag-bag of social conventions which amount to the sentiment—it doesn't matter what you do, it's getting caught that counts".

Yours, etc.,

ALLISTER VALE

East Wing,
Guy's Hospital, S.E.1.

Obeying is not a Duty

SIR,—May I be allowed to add a last-minute comment on the "Sex is here to Stay" controversy?

I think David Boulton (May 27) has hit the nail on the head when he talks about "two thousand years of Christian domination" and social standards which "pay lip service to Christian morality". Surely we cannot expect any moral code to be effective in reducing illegitimacy and adultery unless we obey it. Until recently, we appear to have given assent collectively to the Christian attitude to sex and marriage as being morally right, and as such have incorporated this attitude in our social standards. Individually, however, we are unwilling or unable to make the standard an effective one, and therefore the Christian "domination" which Mr. Boulton mentions can hardly be expected to produce results. The only conclusion we can draw from its apparent ineffectiveness is that there is something wrong with us!

Mr. Boulton says that "Christian sexual morality does not fit the facts of society". In the sense that he mentions, this may be true, but in another sense it is completely untrue. Christ never lived in a dream world, imagining that a "new morality" would by itself provide the solution to the world's problems. On the contrary, He was always aware of man's moral weakness, which is surely one of the most basic facts of society, recognisable just as easily in our day as it was in His. Christ faced up to man's sinfulness and tackled it at its root, by not only laying down moral laws, but also providing the personal strength to obey them.

Thus, when Christians talk about the need, under certain circumstances, for suppressing the sexual drive, they do not mean quite the same thing as a non-Christian might when using the same words. We do not mean that this is something which we force on ourselves as a duty (to society, or God, or anyone else), but something which we want to do because we believe it to be God's will, and therefore the best possible thing for us. The manufacturer should, after all, know the best working conditions for his own goods!

Yours, etc.,

T. M. JACK

East Wing,
Guy's Hospital.

?

SIR,—At grave risk of laying myself open to a devastating barrage from your typrewriters, I, as a humble and faithful follower of evolution at Guy's, feel that I have a moral obligation to protest against your remarks in Passim in your issue of the 13th May.

I find it difficult, but not impossible, to understand the modern idiom. It is not journalese. If this sort of tortuous tautology is peculiar to the *Gazette*, it has little to commend it.

Finally, I resent the hardy-veiled innuendoes directed at the nurses, bless 'em. By universal consensus of opinion, they do a magnificent job of work (day and night).

Yours, etc.,

HAROLD BLOOM

Waverley,
86, Waldegrave Road,
Teddington, Middlesex.

Stargazing

SIR,—Reading Mr. Kenneth Hooper's letter in your last issue, may I say, we live in a mysterious universe.

Yours, etc.,

JOHN C. DOMINICK

Treniffle Lodge,
Lawhitton,
Nr. Launceston, Cornwall.

White Coats for Lesser Mortals

SIR,—May I speak up in favour of long white coats for students? I feel that the wearing of suits on the wards, far from being impressive to patients, immediately marks students down as lesser mortals. Furthermore, I think that a certain blurring of the distinction between staff and students is desirable, and certainly adds to patients' confidence and trust in their captors.

As to expense, surely the hospital laundry could cope with the extra volume of coats? If this service could be rendered free of charge, as at "The London", it would ensure uniformity of cleanliness!

Yours, etc.,

C. QUICK

Students' Union,
The London Hospital, E.1.

Bristol Dinner

SIR,—The occasion of the B.M.A. Annual Representative Meeting in Bristol seemed to Dr. Philip Hickson and myself to be a suitable one to suggest a meeting of old Guy's men and women.

It is proposed to have an informal dinner on the evening of Friday, 7th July, 1967, for anyone interested (with their wives or husbands). The dinner will be held in the Senior Common Room of Bristol University at 7.30 p.m. for 8 p.m., and the charge will be 35/- per head. Would anyone with any connection with Guy's care to write to Dr. Philip Hickson, at Littlecote, Rowden Hill, Chippenham, Wilts., or to myself at Station Road, Epping, Essex.

Yours, etc.,

DR. S. C. C. SCOTT

"My Views on Medical Education"

SIR,—We are running our Students' Essay Prize again this year, the subject being "My Views on Medical Emigration".

Prizes as before will be £50, £25, and £10 respectively for the three adjudged winners.

The closing date for entries is 30th November, 1967, and entry forms and rules are obtainable from the Editor, Medical News, 24, Store Street, London, W.C.1.

Yours, etc.,

DAVID CARRICK, *Editor, Medical News*

OBITER DICTUM

Patient: They don't know what's wrong with me yet. I haven't been properly diagnosed.

QUIZETTE : Dermatology

1. **Nail changes may occur in :**
   (a) Reiter's syndrome.
   (b) Alopecia areata.
   (c) Syphilis.
   (d) Lichen planus.
   (e) All of the above.
2. **Scabies Infestation :**
   (a) Commonly involves the face in adults.
   (b) Sometimes involves the face in children.
   (c) Is caused by the parasite, Demodex folliculorum.
   (d) Is characterised by the presence of burrows.
   (e) Is usually associated with marked pruritus.
3. **Urticaria :**
   (a) Always responds rapidly to antihistamines.
   (b) Can be caused by drugs.
   (c) May only occur in the cold.
   (d) Never occurs in children.
   (e) May follow insect bites.
4. **Psoriasis :**
   (a) Should be treated with oral corticosteroids.
   (b) Is prevalent in temperate climates.
   (c) May respond to topical corticosteroids.
   (d) Generally shows the Auspitz sign.
   (e) Is associated with abnormal dermal capillaries.
5. **Kaposi's Haemorrhagic Sarcoma :**
   (a) Often responds to radiotherapy.
   (b) Occurs in the Bantu in South Africa.
   (c) May involve internal organs.
   (d) May progress slowly for many years.
   (e) Responds to ascorbic acid.
6. **In Erythema Nodosum :**
   (a) There may be upper limb involvement.
   (b) Penicillin should be given routinely.
   (c) Lesions usually ulcerate.
   (d) There is always a history of recent sore throat.
   (e) Sarcoidosis should be excluded.
7. **Basal-Celled Carcinoma :**
   (a) May be treated by surgery or radiotherapy.
   (b) Is rapidly growing.
   (c) Commonly occurs over the face.
   (d) Is slowly growing.
   (e) Should be treated with systemic cytotoxic drugs.
8. **Rosacea (Acne Rosacea):**
   (a) Is a disease of sweat glands.
   (b) Is characterised by comedones.
   (c) Arises commonly in puberty.
   (d) May be associated with gastro-intestinal symptoms.
   (e) Occurs almost exclusively in women.
9. **Malignant Melanoma :**
   (a) Is common before puberty.
   (b) Usually arises from intradermal naevi.
   (c) May develop from apparently normal skin.
   (d) Is most common over the lower extremities.
   (e) May be treated by wide surgical excision.
10. **Common Warts :**
   (a) Are avascular.
   (b) Should be treated with radiotherapy initially.

(c) Are caused by a virus containing deoxyribo-nucleic acid (DNA)
(d) May disappear spontaneously.
(e) None of the above.

11. Erysipelas :
(a) Is due to haemolytic streptococcal infection.
(b) Is usually due to streptococcus viridans.
(c) Is also called erysipeloid.
(d) Involves the face in most cases.
(e) Usually requires systemic chemotherapy.

12. In Herpes Zoster :
(a) There is often pain and tingling in the affected segment prior to the skin eruption.
(b) Thoracic ganglia are affected in the majority of cases.
(c) A susceptible person may get varicella if exposed to zoster.
(d) Susceptible persons usually get zoster if exposed to varicella.
(e) The generalised form is seen most frequently in patients with lymphomas.

13. Ringworm Infections in Man :
(a) May be diagnosed by examining scrapings in 10% potassium hydroxide.
(b) May require griseofulvin therapy to eradicate them.
(c) May involve skin, hair, nails.
(d) May sometimes be acquired from animals.
(e) Should be treated with tetracycline.

14. Hair Fall :
(a) May be self-inflicted.
(b) May occur in iron-deficiency anaemia.
(c) May occur in hypo- or hyper-thyroidism.
(d) May occur with cytotoxic drugs.
(e) All of the above.

15. In Atopic Eczema :
(a) There is a high familial tendency towards hay fever and asthma.
(b) Smallpox vaccination should be encouraged.
(c) Dry skin is not uncommon.
(d) Antihistamines and topical corticosteroids may be useful.
(e) The antecubital fossae are usually spared.

ANSWERS

We would suggest, as the answers may for reasons of space be printed rather closely together, that readers answer all the questions before checking on the answers. We appreciate that the test is considerably more difficult this way.

1. E.(5)
2. B, D, E.
Scabies is caused by a mite, sarcoptes scabiei.
3. B, C, E.(6)
4. B, C, D, E.
In psoriasis, systemic corticosteriods may make the disease worse and their withdrawal often results in an exacerbation of the disease which may be exfoliative.
5. A, B, C, D.
6. A, E.
Lesions do not ulcerate in Erythema nodosum.
7. A, C, D.
8. D.
9. C, D, E.
10. C, D.
11. A, D, E.
Erysipeliod is due to a Gram positive bacillus, erysipelothrix rhusiopathiae. It occurs in people handling infected fish, meat, or poultry, and the organism enters through a scratch in the skin.
12. A, B, C, E.(4), (7).
13. A, B, C, D.
14. E.
15. A, C, D.
Smallpox vaccination is hazardous in the presence of atopic eczema and can produce a generalised vaccinia.

REFERENCES

(1) Andrews, G. C. and Domonkos, A N (1963). Diseases of the Skin, 5th Edtion. W. B. Saunders Co.
(2) Sulzberger, M. B., Wolf, J., Witten, V. H. (1961). Dermatology-Diagnosis and Treatment, 2nd Edition. The Year Book Publishers Inc., Chicago.
(3) Pillsbury, D. M., Shelley, W. B., Kligman, A. M. Dermatology (1956). W. B. Saunders Co.
(4) The Medical Annual 1966, p. 512. Bristol. John Wright & Sons Ltd.

Cont.

(5) Samman, P. D. (1965). The Nails in Disease. William Heinemann Medical Books Ltd., London.
(6) Modern Trends in Dermatology (1966). Edited by R. M. B. Mackenna, p. 52. London. Butterworths.
(7) Smithers, D. W. (1967). Brit. Med. J., 1, 337.

References (1)-(3) are good general references but see also ref. (5) (question 1), ref. (6) (question 3) and refs. (4) and (7) (question 12).

Compiled by JULIAN VERBOV.

MEDICAL WARD ROUND

In the ward, in serried ranks, you find them lying:
Humanity—in divers dire conditions,
And, though moribund, you'll often see them trying
To look alive to please the great physicians.

First Charlie, paralysed and quite aphonic
Has still one hand with which to hold his pipe,
But Sister thinks he ought to have a tonic,
Though Charlie knows his time is nearly ripe.

And George, a man of ninety summers—dying
His only wish at night to sleep a wink.
One registrar, for glory ever vying,
Suggests they ought to do a Serum Zinc.

Poor Arthur, with his circulation failing
And a ruddy great thrombosis in his head.
It's a pity that the Sister's always railing
Cos sometimes poor old Arthur wets the bed.

There's a gastric ulcer bleeding in the corner;
Someone asks could not the surgeons have a go.
But whatever the condition and whoever the physician,
The answer's just the same: it's always No.

Now Tom has got deposits in his liver,
That his bile ducts are obstructed there's a hint.
But instead of cups of tea, they prescribe an E.C.G.
Can't they see the fellow's dying from his tint?

As for Ben, with both his ventricles in failure,
Although he tries, he can't get any breath.
He just wants a kindly gaze—not a blood transaminase,
For he knows that he is mighty near to death.

And Edward, who has tilled the soil for ages
And is crippled with arthritis and "the screws"
Is but meat for all these scientific sages
And an article in "Uric Acid News".

Old Ruben, who has secondaries all over
With an extra special big one in his skull,
They examine with the rest, and percuss his skinny chest
And agree that both his apices are dull.

When at last, with the procession nearly over,
And they've ordered forty "bloods" and ten X-rays,
They should know that all physicians
Are but men, and not magicians,
And that, after life, a man must end his days.

B.D.J.

REVIEWS

BASIC DENTAL ANATOMY AND HISTOLOGY.

F. R. Shroff, Kimpton, London, 1966. 45s.

The author's aim is to provide for the undergraduate student of dentistry a concise account of the "gross and microscopic anatomy of the human teeth and their surrounding tissues".

This 238-page book is divided into two sections of which the first deals with dental anatomy and embryology and occupies 161 pages with 107 figures. Morphology and surface anatomy of the teeth comprises the second section of 59 pages with 73 figures.

The amply proportioned illustrations are of a high standard and have obviously been carefully selected: however, their value would have been further enhanced by including the magnification, together with some indication of the types of stains applied to the tissues from which the photomicrographs have been prepared. Each chapter concludes with a careful selection of appropriate references which are readily available to the reader. All technical terms are well defined in the text so that, in conjunction with the index, specific information can be located with ease.

It is unfortunate that the teeth illustrated in the second edition have been randomly chosen with respect to side. Furthermore, the lower first molar in Fig. 161, chosen as typical, is remarkably like a well-formed lower third molar.

This book provides an adequate basic introduction to the subject and is not over-priced at 45s.

O.

THE TEACHING HOSPITAL—EVOLUTION AND CONTEMPORARY ISSUES.

Edited by J. H. Knowles, M.D. Harvard University Press. 1966.

The four Lowell lectures which comprise this book have two themes in common, both relevant to our own situation in Britain. The first is that tradition helps to an understanding of the past, but serves more as a foundation for further advance than as an excuse for conservatism. We are rightly proud of our tradition at Guy's, especially when a book such as this acknowledges the contributions to progress of Sir Heneage Ogilvie and Professor Hedley Atkins. How far though are we joining our colleagues in the U.S.A. in meeting changing demands with changes in our teaching hospitals?

The second theme is an answer to the question one hears raised so often. "But we cannot afford to keep going as we are, how can we expect to finance an improved system of teaching?" Dr. Knowles and his collaborators believe that an untapped source of patients and money could be released for teaching if paying patients were brought into the orbit of the teaching programme. Private insurance schemes are expected to extend in the future. Finance from such a source could possibly be fed back into any teaching hospital at which treatment services were provided under the scheme.

Transatlantic exchanges of ideas are likely to continue, and will, we hope, increase. At Guy's we are reminded that the two recent student visitors from the U.S.A. who wrote up their experiences in the Gazette were frank and helpful in their comments. They saw us in our traditional setting, praised the detailed care of the individual patient, but realised what tremendous opportunities for learning many of us allowed to slip by. Their comments fill in a gap which Dr. Knowles leaves in his book. There is no mention in the index and only indirect reference in the text to the place of the student in the teaching hospital. Just as the proverbial horse is led to water, the student can be provided with patients, finance and teaching. What makes him take and enjoy what is offered?

H. F. LUNN

THE MECHANISMS OF TOOTH SUPPORT. A SYMPOSIUM.

Organising Committee: D. J. Anderson, Department of Physiology, Guy's Hospital Medical School, London, S.E.1; J. E. Eastoe, Department of Dental Science, Royal College of Surgeons of England, London, W.C.2; A. H. Melcher, Department of Dental Science, Royal College of Surgeons of England, London, W.C.2; D. C. A. Picton, University College Hospital Dental School, London, W.C.1. 176 pp. with 120 illustrations, 1967.

John Wright and Sons, Ltd., Bristol, England. *Price* 42s.

The organising committee state that the symposium reported in the present volume was planned to bring together research workers in an attempt to resolve some of the problems associated with research into the basic mechanisms which cause teeth to erupt and which provide their support during function.

The list of papers and authors is indeed impressive, both in the scope of the work and in the eminence of the research workers who gave the reports. There are six sections devoted to different aspects of the subject under discussion. These were " A Review of the Fundamental Properties of Connective Tissue", "The Dento-gingival Junction", "The Arrangement of the Tissues in the Periodontium", "Eruption", "Adjustments of the Supporting Tissues During Function", and "Tooth Mobility". Although perhaps the undergraduate student might find the going rather difficult, especially in the opening section, nevertheless there are many areas where even occasional selected reading will be of considerable assistance in many parts of the dental curriculum. The reviews at the beginning of each section are particularly clear and provide a valuable summing-up of current thought.

The reporters have here contributed a great deal to current knowledge, but they have been generous enough to leave very many questions unanswered. The newly-intiated research worker will certainly be stimulated by this book to seek the answers to some of these problems and he will have as a guide the many immaculate examples of careful research here reported.

It is a great pity that, as the committee states, in order to keep the cost of production at a low level the present method of printing which is so unattractive, was adopted. The absence of the discussions of the papers, for the same financial reasons, is regrettable because this must have been one of the prime reasons for the assembly of so many brilliant workers from all parts of the world.

This book should be in the possession of all dental research workers and in dental libraries where it may perhaps be used as a basis for further fruitful discussions among teachers an dstudents.

J. O. Forrest

'PROCEEDINGS OF A SYMPOSIUM ON SPINA BIFIDA'

Published by the National Fund for Research into Poliomyelitis and other Crippling Diseases, London. *Price* 42*s*.

The symposium, which was held in London in June 1965, was attended by many of the leading British pathologists, paediatricians and surgeons caring for children who have spina bifida. The monograph contains papers from this meeting together with some of the discussion.

The most interesting sections are those by the surgeons—neuro, genito-urinary and orthopaedic—who have made such outstanding contributions to the management of these children. At times the discussion reveals the wide differences that exist between them, as well as between different paediatricians in the selection (if any) of babies for early surgery.

Whilst the papers describing the advances in the surgical management of spina bifida are stimulating and exciting, one cannot help feeling rather frightened about the social and economic consequences of modern skilled treatment.

S. R. Meadow

NURSING SECTION

Domestic Duties

At the beginning of April the General Nursing Council sent copies of letters to Matrons of hospital nurse training schools, expressing concern at the continuing practice of requiring student and pupil nurses to undertake domestic duties on the wards.

"The Council's inspectors have found on visits to training schools that it is still common practice to undertake domestic duties. Student and pupil nurses may be called upon to carry out routine tasks such as ward dusting and cleaning of baths, sinks and sluice room equipment, and if there is a shortage of domestic assistants they may be required to help with the ward washing-up and sometimes sweeping of floors in the evenings and at the weekends."

While it is recognised that whoever is carrying out domestic duties is doing it for the benefit of the patient, the Council is determined to prevent student nurses from being exploited and used as cheap labour.

Indifference, in the past, on the part of the hospital management committees has led to inadequate trouble being taken to employ domestic assistants, and the principle has usually been that the nurses will cope and do it all. In comparison, the nurses' employers spend vast sums of money in trying to recruit student nurses and lighten the burdens of the nursing staff, only to have them undertake domestic tasks.

The emphasis in recent years has been for hospitals to employ ancillary staff —receptionists, aides and auxiliaries to allow nurses to undertake nursing skills only. Where this has been implemented there is satisfaction amongst the nursing personnel who are able to pay more attention to the patient and to technical nursing.

One can appreciate the difficulties of domestic staff managers if the hospital is situated in a particularly underpopulated area, but there are means of recruitment of domestics, and where enough time and trouble is taken hospitals have managed extremely well.

There is much support for the argument that it is an ideal opportunity to talk to the patient when you are cleaning his locker and many are the advantageous conversations that have been carried out over the wet dusters. However, when this is done to the exclusion of nursing duties then the matter needs reconsideration.

No one wants to see a state of affairs in which either nurse or domestic refuses to do something because it is not her job—trade unionism can never be synonymous with nursing but differentiation between looking after the patient and being a pure domestic is very important.

It is to be hoped that if management committees are financially unable to employ more domestic assistants, then the Ministry of Health will be only too ready to take over the financial responsibility .

STAFF CHANGES AND APPOINTMENT

NEW APPOINTMENT
S/N J. Scott (Guy's 1960-65) to Luke Ward.

DEPARTURES
Sister S. M. Mortley, from Casualty.
S/N S. Carruthers, from Casualty.

S/N B. Fraser from Surgical Out-Patients.
S/N J. Rickitts from Miriam Night Duty.
S/N M. Rushforth from Front Surgery.
S/N L. Pavitt from Hurst Ward.
S/N E. Talbot from York Clinic.

SPORT

CRICKET

At present Cricket spells collapse for Guy's. As a side they are weak; individually a good performance is seen from each in turn throughout the season. But as yet they are unable to produce a solid combined attack. Perhaps a competent opening partnership might lead to a less flustered and harassed performance by the remainder of the side.

We should mention that Appleby has batted consistently well, but has lacked support—very evidently against St. Thomas' in the Semi-final of the Hospitals' Cup, when Guy's lost by 28 runs. Of the bowling, Pearson lived up to expectations with a fine 6 for 51 against Reigate Pilgrims and Davoodbhoy also took 5 for 56 against St. Thomas'. Both also bowled well against Crofton Park.

Although we can find reasonable scores on occasions from Thompson, Swift, Chase, Clark, and Butchey, as yet they have not shown any consistency for high scoring, and it is tempting to review these performances as lucky moments.

GOLF

DENTAL STAFF v. DENTAL STUDENTS
Selsdon Park Hotel Golf Club, 25th May, 1967

Mr. Mansie, J. W. 1 Mr. Lamb, W. T.	Cripps, N. N. 0 Roberts, M. N. D.
Mr. Bret-Day, R. C. 0 Mr. Cardwell, J. E.	Adams, M. P. D. 1 Phillip, A.
Mr. Richards, H. 1 Mr. Naylor, M. N.	Davidson, D. W. 0 Cunliffe, J. S.
Mr. Stewart, A. J. 1 Mr. Baker, A. W.	Kingsbury, J. 0 Ritchie, J. S.
Mr. Rowe, C. ½ Mr. Winning, C. W.	Evans, D. ½ Graham, D. A.
Mr. Riley, A. A. 1 Mr. Burley, A. T.	Wood, J. F. 0 Poole, S. J.
Result: Staff 4½	Students 1½

This annual meeting as always provided a most excellent day's golf for victors and vanquished. The serious business of the day, the actual match, was fought after lunch, but during the morning session, the players were able to survey the course and acclimatise themselves to some advantage to combat the rather wet conditions that were forecast for the afternoon round. Fortunately, rain was endured only for the last few holes! A clear win for the staff's side resulted.

DIARY

CRICKET

June 10.—Teddington. Home. 2.30 p.m.
June 11.—Hampstead. Away. 11.30 a.m.

BOAT CLUB

June 3.—Walton Regatta.
June 10.—Reading and Horseferry Regattas.
June 17.—Harlow and Putney Town Regattas.
June 24.—Richmond Regatta.
June 28—July 1.—Henley Royal Regatta.

BOAT CLUB

United Hospitals May Bumping Races

In these races, crews start one behind another and by rowing faster than the crew in front attempt to "bump" it. These then change places on the following night.

This year the bumps were held on the 8th, 9th and 10th May over an 8 min. course at Kew.

The 1st. VIII, starting fourth made two very lose attempts on the first two nights and on the third night convincingly bumped St. Thomas' 1st VIII, so we are now 3rd.

The 2nd VIII bumped St. Thomas' III and Barts III and therefore go up two places. The 3rd VIII bumped Barts IV who bumped them again the next night.

The Bumps Supper was held at the London Rowing Club after the last day's racing, and was enjoyed by nearly 50 members. The Coxes received a traditional dip in the Thames.

Thames Ditton Regatta, 13th May

The 1st VIII entered Junior-Senior Eights at this popular early regatta. Guy's met Eton College in the first round. For two minutes the crews were level but after a structural failure and some odd steering in the Guy's boat, Eton pulled away to win by 1¼ lengths in the fast time of 4 mins 7 secs.

Hospitals Boat Race

Guy's and Barts row annually for the "May and Baker Cup" (1st VIII's) and the "World Medicine Challenge Shield" (for 2nd VIII's)

Barts won the Cup after a close race which ended in a collision (too close!). The Guy's 2nd VIII, easily beat Barts II by numerous lengths and proudly bring the huge shield back to its place in the Medical School Office.

Crews

1st VIII: Bow, A. Batch; 2, P. Moulder; 3, G. Straggall; 4, N. Bax; 5, A. Hogkison; 6, J. Miller; 7, J. Pook; Stroke, R. Forrest; Cox, T. Kirk.

2nd VIII: Bow, P. Robinson; 2, R. Tudor Williams; 3, N. Pinkney; 4, J. Skuse; 5, J. Swain; 6, A. Fenn; 7, M. Fortune; Strokes, K. Sommi and P. Hunt; Cox, R. Stanley.

GEOFFREY STYGALL (Hon. Sec.)

ATHLETICS

GUY'S and L.S.E. v. IMPERIAL COLLEGE

At Victoria Park. Sat. 20th May

Both Guy's and L.S.E. had very poor support for this match so a combined team was formed to compete against Imperial college. A heavy downpour of rain postponed the start for half an hour and left the track and grounds very wet. J. Price won both the long jump and 100 yds in fine style and then tried his hand at the discus for the first time but found this was not so easy as it looks: he was in the process of winning the shot put for us when the second downpour caused the match to be abandoned. G. Voss won the discus convincingly but found competition in the sprints to be very keen. The L.S.E. part of the team gained a 1st and 2nd for us

This match started with poor support and disappointing weather conditions but turned out to be a close competition until it was completely thwarted by the weather.

Results—

J. Price 1st L-J; 1st 100 yds.; 1st shot; 4th discus.
G. Voss 1st Discus; 2nd shot; 4th 100 yds.
D. Choat 1st 880 yds.; 2nd 440 yds.

U.H. FIELD EVENTS AND RELAYS COMPETITION

Wednesday, 31st May, 1967

Result: Guy's, 1; Westminster, 2; London, 3; St. George's, 4; Middlesex, 5.

Heavy rain during the previous night left the track very wet and heavy, but fortunately the afternoon was fine and warm. Although six hospitals entered for the competition, most of the teams concentrated on the relays, so that there were only three hospitals (Guy's, Westminster, and London) competing in the Javelin and Discus: in the Weight and Hammer only Guy's and The London competed. D. Osborne, A. Ross, R. Bailey, and G. Voss comfortably won all the throwing events between them, thus giving us a good lead. In the jumps, we were well beaten by the Westminster.

Unfortunately, the 4 x 440 yards relay had to be abandoned owing to lack of entries from other hospitals, which left the 4 x 110 yards relay and the Medley relay to be won by Guy's. In both these, D. Barford and F. Nwator ran very well and I. Morgan gave us a safe victory in the Medley relay.

Results:

4 x 110 yds. relay—1st, Guy's
Medley relay—1st, Guy's.
H.J.—2nd, Guy's.
L.J.—2nd, Guy's.
Weight—1st, Guy's.
Discus—1st, Guy's.
Javelin—1st, Guy's.
Hammer—1st, Guy's.

CRICKET

Semi-final Hospitals' Cup

GUY'S v. ST. THOMAS'S

1st June, 1967

St. Thomas's: 178. (Read, 56 n.o.) (Davoodbhoy, 5—56.)

Guy's: 150. (Appleby, 56.)

St. Thomas's won the toss and to our surprise elected to bat on a wicket which would favour seam bowling.

Guy's made a good start, and after about two hours' play St. Thomas's were 84 for 7. From this point onwards things started to go wrong for Guy's, and three fairly easy catches were dropped, allowing the score to rise to 140 for 7 at lunch.

After lunch Guy's made a further breakthrough due to good bowling by Davoodbhoy. Once again we hoped that we might keep our opponents' score down but a valuble thirty runs were scored for the last two wickets.

Guy's started to bat with plenty of time in which to get the runs, but a good start on which to mould this score did not materialise. Our opening partnership once again failed to succeed, leaving Guy's 21 for 2. Clark and Chase batted out the last hour before tea, against good seam bowling, adding only 20 runs. After tea, however, this partnership was broken, so that with the score at 69 for 5 Guy's were not in a good position.

It was not until Appleby came to the wicket that Guy's appeared to have a chance of winning. We saw a superb display of controlled batting which carried us to within reach of our opponents' total Unfortunately, however, Appleby was run out and our chances of victory faded. The remaining batsmen put on only one run between them.

We felt, however, that if we had taken our chances in the field that we would have had a very good chance of winning. Congratulations to St. Thomas's who will probably go on to win the Cup for the third year in succession.

GUY'S v. CROFTEN PARK

Result: Guy's won by 62 runs.

Guy's: 153. (Chase 53, Appleby 32, Thompson 26).

Crofton Park: 91, (Davoobhoy 5-39, Pearson 3-20)

Having had at least 7 matches cancelled so far this season, our Cricket Team was only too happy to see a glimmer of sunshine despite the bad weather forecast. Guy's started to bat at 11.30 a.m. but it soon started to drizzle fairly heavily and the question of continuing was in everyone's mind. Play nevertheless went on and Guy's were soon in trouble losing Butchey and Clark fairly early. Chase, Appleby and Thompson, however, all batted very well to allow Guy's to reach the modest total of 153.

Crofton Park started off very well and at tea-time with the score at 10 for 0 we were feeling pretty pessimistic. Tea did not seem to go down too well with Crofton Park, as the post-tea period produced a dramatic collapse which was mainly due to very good bowling by Davoodbhoy and Pearson aided by good ground fielding and excellent catching by the rest of the team. A pleasant evening with us finishing up in the Crofton Park pavilion brought an enjoyable day's cricket to an end.

J. R. K. BUTCHEY

GUY'S v. REIGATE PILGRIMS

Reigate Pilgrim's: 148. (Baker 42) Pearson 6 for 51.

Guy's: 81 for 6.

The weather forecast wasn't good, the night before had been too good for a few but despite this the chosen eleven were gathered under bright skies on that interesting sloping pitch at Reigate.

Our opening attack was distinctly rusty. The moist wicket didn't help and the Pilgrim's openers soon got into their stride.

Pearson was introduced earlier than usual, this was his ground, (he captured seven wickets last year). Our likeable slow, left-armer was soon weaving his magic spell over the opening batsmen. One of the latter was our old friend, Ian Reekie, who is well known for his entertainment off the field of play, and also proceeded by some fine batting to entertain on the field. He was soon out after lunch, one fort too many was the trouble, I think.

Pearson and Crafts finished off the remaining batsmen, helped by a particularly fine diving catch by Thomas at extra cover. Pearson finished with a very creditable 6 for 51.

The skies began to cloud over as we went into bat and similarly a shadow seemed to hang over the Guy's batsmen. The general depression was lifted momentarily by a massive Clark six into the car park; he was run-out, unfortunately, soon after. Silk, to be truthful, had his mind on other things, and Reekie's description of the unfortunate batsman's brief innings was a joy to hear.

The heavens opened soon after tea and even the arrival of the entire Crafts family (how pleasant it was to have some support) didn't prevent the downpour, and we retired thankfully early to the more jovial surroundings of the Red Lion and to Ian Reekie's own peculiar brand of entertainment.

R. J. BEACHAM

HOSPITAL INFORMATION

PRIZE

GOLDING-BIRD GOLD MEDAL AND SCHOLARSHIP IN BACTERIOLOGY

R. H. Greenwood— Medal and Scholarship

PASS LIST

THE CHARTERED SOCIETY OF PHYSIOTHERAPY

Final Examinations, May, 1967

Cameron, G. M.
Glegg, M. L.
Glover, A. M.
Hills, R. E.
Knott, E. A.
Lee, P. M., Mrs.
Midgley, D. J.
Paynter, A. L .
Rundle, G. P. C.
Smith, J. M.—Credit
Webb, S. H.

PERSONAL

ANGLIA d/l Nov., 1962—For sale. Only 2 owners 50,000 miles. In excellent condition Radio. £245 o.n.o. Contact Robins, East Wing, Guy's Hospital, S.E.1

GETTING MARRIED?—New unfurnished flat in Wallington for Dental Assistant. Own nameplate, telephone and E. C. Numbers. Write 3 Hillcroft Avenue, Purley, Surrey. Mr. D. J. W. Foster, L.D.S.R.C.S., 137 Harley Street, London, W.1. (practice)

CHANGES OF ADDRESS

Dr. F. D. Higgs, Kabarole Hospital, P.O. Box 37, Fort Portal, Toro, Uganda.

Andrew and Rosilind Mills, (née smith) 177, Sheen Lane, Sheen, London, S. W. 14.

Dr. and Mrs. Richard Reynalds, 86 Lyall Street, Kalgoorie, W. Australia.

BIRTHS

ARMSTRONG—On April 29th, 1967, to Virginia (Thompson-McCausland) and Angus Armstrong, a daughter, sister to Dominic Heartherley, Rothbury, Northumberland.

REES—On 26th May 1967, in Gloucester, to to Sandra (née Evans) S.R.N. and Hogh Rees M.B., B.S., a daughter, Emily-Jane.

REYNOLDS—On April 23rd, 1967, at Kalgoorlie, W. Australia, to Barbara (née Allen) and Dr. Richard Reynolds, a daughter, Judith Mary, sister for Sarah, James and Matthew.

We would like to remind our readers that all copy for inclusion in the Gazette must be received eight days before the publication date.

Personal notices one shilling per word (Minimum £1. 1s. 0d.)
Birth, Marriage, Death and Change of Address notices are without charge to subscribers.
Non-subscribers will pay £1. 1s. 0d. for all notices other than Personal.

GUY'S HOSPITAL GAZETTE

EDITORS D. S. ROBINS and C. B. BROWN
SPORTS CORRESPONDENT J. G. PAYNE
NURSING CORRESPONDENT E. A. MALPAS

FORTNIGHTLY TWO SHILLINGS VOLUME 81 NUMBER 2059

The opinions expressed in these columns are solely those of their authors and are not to be taken as the views of the Hospital as a whole.

PASSIM

Old Folks—Old Inaction

Night round: Mrs. S—no change, Mr. W—the same, Mr. A—still the worst offender of the night stillness (a smile), Mrs. B—has gained 7 lbs. in the past 17 weeks, Miss E—nothing to report . . . etc. Mrs. Q—still waiting for the geriatricians to come: then a brief, impassioned duologue about acute medical beds full of "crumble", nothing to do for him, her or her except wait for Godot, and about the total lack of effective organization in dealing with geriatric patients whose disease is often simply old-age and its slow-moving consequences.

The scene is set by clinicians and academicians who fret over "blocked beds", blocked because the "damn geriatric people" are always finding excuses why they shouldn't take over cases, and by geriatricians who resent being considered the failed clinician or academician who should be given the patient when there is nothing more of teaching interest to be squeezed out of the case or when nothing more active in the form of investigation or attempts at curative therapy is considered worthwhile. The theme is the protection of empires which have blocked minds, unsubtle innuendoes and masterly inactivity as their executive arms. And all of this providing the Press with ideal fodder for sensational, revealing articles and correspondence columns wind for the indignant screams of the socially outraged concerning the shocking treatment of the aged who are in hospital—a place where they are received often from the reluctance of relatives and the letter writers to consider their own responsibilities. The final touches are added by those who directly have to make some kind of sense out of the whole insensible scene.

In the article published in this issue we have the case of the Geriatric Department at New Cross, a case with figures to show that the department and its works are much more than the medical backwater it is often claimed to be. It is a brief look at a section of

medicine where the organization and staff are specially prepared and selected and where the maxim of total patient care is solidy upheld. It is an explanation of one side of the matter but also hints at some form of solution to the problem. The problem?

Quite apart from the attitudes of those concerned with the care of the aged, there exists the unsatisfactory milieu in which this care has to be performed. The rumbling of a part in a machine often means more than merely a weakness in that part: it may signify a generalized weakness, sometimes serious. The weakness does exist, and through the tardiness of the manufacturers we continue to see the wrong patient in the wrong bed at the wrong time.

We are told that there is a shortage of hospital beds, doctors and nurses to care for hospital patients, and of course a shortage of money. We observe the frustration of those who tend the chronic aged patients in the acute medical bed, a frustration which the socio-moral shoulder-chip-bearers interpret as inhuman, callous and, of course, scandalous medical behaviour. These clamourings could much more worthily and constructively be aimed at the Ministry who fail to appreciate or to act effectively if they have appreciated that for the price of a week's stay in the acute medical bed in a London teaching hospital for a patient who needs little more than a modicum of medical attention, rather more personal attention and rehabilitative encouragement, they could provide the necessary accommodation for at least two such patients elsewhere.

But then, of course, we would be getting somewhere.

Up from the Ape

The brain of our primate ancestors trebled its size in about one million years: a rate of development a hundred times faster than the evolution of the horse's leg. The question of how we developed from animal stock must be genetic. But what special sort of breeding system could exert such strong selective pressures resulting in this cerebral revolution?

Robin Fox, in the recent Malinowski Memorial Lecture, suggested that man evolved from creatures living in a baboon-like social structure: a group of dominant males, their mates and a fringe of subordinate males. But the society was organized on a different physiological basis than present-day baboons.

Fox argues that the early female primate must at some time have lost the oestral cycle of intermittent fertility, being replaced by a more frequent ovulatory cycle. At the same time the males were growing to a size not much larger than the females and coming to sexual maturity at the same age.

These two tendencies may have produced a breeding system which selected in favour of brains. Thus, as the males began to mature faster, the proportion of males and females in the population would become more equal. That would have intensified the compe-

tition for females, and with more frequent ovulatory cycles and permanent sexuality the competition would become even more intense.

Survival from being eliminated from the breeding system or being killed under simultaneous circumstances would have led the male to make many simultaneous decisions about controlling his sexual and aggressive desires. This set-up would favour the male with a brain efficient enough to inhibit and control his behaviour.

This view of human intellectual evolution would appear to satisfy two rival explanations of human origin, that of Freud and that expounded in the Bible.

Freud supposed that some crisis of sexual jealousy. leading to parricide must have resulted in the proto-hominids developing into a society of rule-obeying, guilt-feeling humans. As for the Bible, the story of the Garden of Eden is here well supported—females started all the trouble and so took us out of the state of animal innocence.

That Name Again

It requires far fewer rapid verbal repetitions of the name of this hospital, compared with the more traditionally or geographically named hospitals, for "Guy's" to sound a most peculiar word. Such verbal perseverance is obviously spreading, for two letters have recently been received, the first addressed to Gut's Hospital, and the second to Gwis Hospital. The latter, believe it or not, came from one of the largest drug firms in the country.

Accident

The relief with which we greet the closing off of Great Maze Pond to vehicular traffic this week is much more than that which recognizes an obvious sign of activity about to begin closer to the site of the Tower Block than we have so far experienced. In the past three weeks at least two collisions have occurred between a car driving down St. Thomas's Street and one coming rather too quickly and without due regard out of Great Maze Pond. The second of these necessitated an ambulance being called. What with the experience of the long wait that was necessary some years ago for the positioning of a zebra crossing, it would seem highly desirable that the authorities should plan *now* for the erection of a warning signal to motorists who are leaving the hospital by the normal route to beware of the heavy traffic in St. Thomas's Street. The Casualty Department is not that short of work.

The Great Patch-up—cont.

William Gull ward. reconstructed after the damage to Hunt's House inflicted in the last war, closes for repair again. At the same

time the new lift, of extraordinary proportions, has begun operating in the same building, so that we now have an improvement in our ability to transport patients to a ward which will only accept healthy workmen. The confusion which exists in the Middle East, where the same word is used for hello and goodbye, has apparently spread to Guy's—are we coming or going?

Mens et Corpus

With the Physiology Theatre packed as it is only for Residents' Plays and Theatre Club productions, we were taught-in on Homosexuality and the Law last Monday. Mr. Leo "I am not the Messiah" Abse and Dr. David "I am also a member of a persecuted minority" Stafford-Clark gave appealing lessons. The response from the floor was such that made us ponder over the appeal of this subject as against the apparent lack of appeal of the now-cancelled Midsummer Ball. Healthy minds—Healthy bodies?

We extend our warmest congratulations to Professor Hedley Atkins and Mr. J. B. Blaikley, who were awarded the K.B.E. and C.B.E. respectively in the recent Birthday Honours. The lesson is obvious, as is the vicarious pleasure it has afforded to so many.

We draw attention to the availability of accommodation for Registrars in Sarah Swift House, a minute's walk from the Hospital, as detailed in the Notices, page 338.

We would remind readers that the index for the issues of the *Gazette*, Vol. 81 (1966) will shortly be available, and orders should be sent to the Manager with little delay.

GUY'S DIARY

JUNE			EXHIBITION: In the Gordon Museum. "Haematuria."
24th	Sat.	1.00	Clinico-Pathological Conference. In the Clinical Theatre.
27th	Tu.	1.00	Clinical Lecture. Dr. STIMMLER. "Hypoglycaemia in the Newborn Period."
30th	F.	1.00	Clinical Lecture. Dr. SCOTT. "Pleural Effusion."
		2.15	Combined Round. Prof. A. G. BEARN, Cornell University, New York. "Inherited Disease".
JULY			
3rd	M.	7.30	Music Club Concert. In Nurses' Sitting Room.
4th	Tu.	1.00	Clinical Lecture. Dr. MANN.
		5.00	Pupils' Physical Society. In the Anatomy Theatre. Dr. R. HOLLAND, talking about his medical work in West Pakistan.
7th	F.	1.00	Clinical Lecture. Mr. BRAIN.

OLD FOLKS IN HOSPITAL BEDS

by

A. J. ROSIN

Department of Geriatrics, New Cross Hospital

A newly-qualified houseman will not take long to notice that a substantial proportion of hospital beds are occupied by old people. Many of them may remain in hospital for a long time, and the expression of "blocking a bed" creeps into his overall assessment of the individual case. The nature of the illness and the social difficulties so often encountered with elderly patients will prompt the dispatch of a letter to the local geriatric department (and rightly so!) asking for help, and for transfer of the patient.

When, some time later, he enters general practice, he will soon be faced with a large number of old people in various degrees of disability, many living in straitened circumstances. The admission of a patient to hospital often becomes an urgent necessity after a relatively minor incident, such as a series of falls. Difficult social circumstances and the progressive nature of chronic illness may also cause the general practitioner to call on the geriatric unit in the area with a request for admission.

These requests from general practitioners and from hospitals form two recurring and sometimes competitive themes in the life of a geriatric department. Anyone working there is soon obsessed with beds, or rather the lack of them. The triumph of discharging a patient is reflected not only in his home-going, but also in making available a bed to admit one of many clamouring at the hospital gates. The bed occupancy is usually around 100 per cent or very close to it all the time. In geriatric practice, therefore, the doctor is concerned not only in diagnosing, investigating, treating and rehabilitating

patients, but also in creating empty beds to reply to the demand on his services. In this paper, I have attempted to show something of the nature of the demands on the unit, and how these are answered. The figures given deal with the statistics for 1966 from New Cross Hospital.

DEMANDS. Referral of patients takes place from general practitioners who see them at home, from hospitals and from residential homes. Most of them are referred with a view to being admitted to hospital. The geriatric service is often the last avenue of attempted disposal or placement of these patients. If the geriatric physician has insufficient beds for in-patient care, he must be ready to suggest a reasonable alternative.

Table 1
The demand in 1966.

Source	Accepted and admitted	Not accepted for admission	Accepted but not admitted
Home	281	86	19
Hospital	62	18	28
Residential Homes	18	0	0
Total ...	360	104	47

These figures can only become meaningful when related to numbers of beds. Although one long-stay ward was not actually administered by the department until October, 1966, its beds are included in the total of 181 beds. Of these, one male ward, one female admission ward and one female rehabilitation ward comprise 78 beds, although some long-stay patients were kept in these wards, too. The other wards, three female and one male, totalling 103 beds, are chiefly for long-stay patients.

Relating the demand on beds to the availability per 100 beds per week, we find that the total demand accepted was 4.3 patients per hundred beds per week. Some who were not accepted at first were subsequently admitted; e.g., after out-patient investigations. The total of 390 gives a ratio of 4.14. Those accepted but not admitted constituted a proportion of 0.5 patients per 100 beds per week. The reasons for non-admission were as follows:—

Table 2.

Hospital patients :		
Died before transfer		18
within one month	9	
over one month	7	
dates unknown	2	
Sent home		7
Sent elsewhere		3

Patients at home :

Taken elsewhere	7
Refused admission	4
Died before admission	8
Total ...	47

Thus for these reasons, about one-eighth of patients accepted for admission did not enter the geriatric unit, although some of the deaths were within a short time of referral. The disposal of those not accepted for admission made demands on other departments thought to be more appropriate, or on services other than in-patient management in the geriatric unit.

Table 3.

Hospital patients not accepted for transfer to geriatric department.

Referral to Welfare Department	7
Suggest discharge home (1 re-admitted)	6
Patient from outside catchment area	4
Nursing Home suggested and arranged	1
Patient left in ward	1
	19

Of 86 patients referred from their own home, 42 were deferred to geriatric out-patients—a useful safety valve. From these some were subsequently admitted—the final total of admissions is therefore higher than those accepted for admission. Twelve were notified to the Welfare Department and four acute cases were refused because of lack of beds. Others were dealt with as Day-patients attending the ward, or were referred to more appropriate specialists, such as to the surgeon or the psychiatrist.

WAITING TIME. Every department in a general hospital is affected by the turnover of geriatric beds (except the children's ward). Inadequate beds will increase waiting time of old people accepted for transfer. On the other hand, a slow turnover reduces the services available to the community, and patients who should be accepted from general practitioners straight to a geriatric department have to be channelled to other wards. The ratio of early admissions to late ones as represented by one week and one month respectively, gives a measure of the adequacy of beds.

Table 4.

Waiting time	3 days	7 days	14 days	one month	3 months
Home	161	51	23	16	3
Residential Homes		17	1	0	0
Hosiptal		12	13	4	23

This does not include all patients admitted as no waiting time can be computed for such cases as arranged holiday admissions, planned intermittent admissions, etc. The ratio of early and late admissions is as follows:—

Table 5.

	Per cent total admissions	Per cent of referrals from home	Per cent of referrals from Hospital
Early admission			
Waiting up to one week ...	62	83	20.7
Intermediate			
Waiting one week to one month	9.5	9	22
Late			
Over one month's waiting ...	14	7.5	57

About 62% of the patients came into hospital within one week of acceptance but 14% were delayed for more than one month. Over half of the late admissions were transfers from hospitals.

The inadequacy of long-stay hospital accommodation is indicated by the number of late transfers plus the number who were accepted but could not be admitted, viz., 33 and 28 respectively. This is approximately one-eighth of the total annual turnover. Thus, to reduce the waiting time of all patients to within reasonable limits would require an addition to the 181 beds of a further 23 beds.

AGE STRUCTURE. Seventy per cent of all patients admitted were over 75 years; twenty per cent were over 85. This was similar to the age ratios in 1965, and is an indication that despite the nominal age boundary at 65 years, geriatric wards deal with a greatly aged population.

DISCHARGES AND DEATHS. Another important factor influencing waiting time is the turnover rate, i.e. the rate at which beds are cleared whether by discharge of the patient or by death.

The total number of discharges and deaths throughout 1966 were:

Discharges	...	256
Deaths	...	133

Figures referring to the outcome of the patients admitted during this time were not synonymous with the recorded discharges and deaths in the year, as some died or went home in 1967, and some admitted in earlier years died or were discharged in 1966.

However, analysis of the outcome of admissions in 1966 gives an indication of the rate of turnover.

Table 6.

	No.	% of admissions
Discharged home	159	40
Residential Homes	33	8.4
Death	95	24
Long-stay	70	18

Table 7.
Duration of stay in the ward.

Weeks	1	2	3	4	6	8	10	12	More than 12
Discharge									
Female	—	23	25	14	25	19	5	6	20
Male	—	4	11	12	8	6	5	5	4
Total		27	36	26	33	25	10	11	24=191=40%
Death									
Female	13	5	10	4	12	4	2	2	8
Male	3	2	9	3	8	2	2	2	4
Total	16	7	19	7	20	6	4	4	12= 95= -24%

Follow-up of patients admitted during 1966 show that 50 per cent were discharged. Eighty per cent of these returned to their own homes, sometimes after a spell of convalescence, and 16 per cent to residential accommodation. About 50 per cent of the discharges occurred within a month and 70 per cent within six weeks. The death rate this year showed several peaks over a three-month period. This might indicate that as well as serious and terminal illness causing early death, subacute and longer-term illness contributed to the clinical load.

The occurrence of death within three to four weeks would suggest that the patient could not have been discharged. On the other hand, these increased durations of stay slow the rate of availability of beds.

RE-ADMISSIONS. Return to hospital for the same illness or for a different cause is not unexpected in a sizeable proportion of old people.

Table 8.
Analysis of the nature of re-admission.

	Male	Female
Requested	13	24
Planned	1	5
Early (within one week of discharge)	3	5
Sent to other hospital	1	4

A total of 48 re-admissions (12%) took place. Six patients were admitted on a planned intermittent basis to give their relatives a rest. The total is lower than in 1965 and therefore would suggest that more patients discharged are able to remain satisfactorily outside hospital. The outcome of those re-admitted was that 11 died, 17 were again discharged and 7 became long-stay. The outcome of 5 others was uncertain at the time of writing.

DISCUSSION

The fact that 40 per cent of patients were admitted within 3 days of referral and over 60 per cent within 1 week indicates a fair access to the geriatric department for general practitioners. The combination of a difficult social background, infirmity and acute illness in old people make the possibility of early admission from home essential for the running of an area geriatric hospital service. These figures do not, however, take into account a number of cases referred by the Emergency Bed Service, who were refused because of the lack of an empty bed.

The hospital represents only one facet of the care of elderly infirm people in our society. Although a geriatric department must take responsibility for the permanent care of a certain number of these people, it is not a dumping ground for disabled people who are difficult to place. One of its essential tasks, however, consists in the assessment of residual function and rehabilitation after recognition of disability and correct placement of the individual in a suitable environment.

What factors are responsible for retarding the increased use of beds in the geriatric unit and what facilities are needed to answer the problem?

(I) *Outlet from hospital.* Suitable accommodation with adequately supportive services must be available for old people awaiting discharge. Council building programmes, availability of flatlets for old people and the general standard of housing have their effect in facilitating or retarding discharges. The delay in the Welfare residential accommodation building schemes has resulted in large waiting lists for Council (Part III) Homes. At any one time in the past 18 months, there have been between 20 and 25 patients accepted by the Welfare department but waiting in hospital for vacancies in Homes. The geriatric team must have a close liaison with local resources directed towards community care, which should be used to the full, for after-care of their patients. This includes home supervision and help, district nursing, day centres and club facilities, visits, etc. Limitations of these facilities may also cause increased stay in hospital of house-bound old people.

(II) *Development of out-patient services in the geriatric department.* It is recognised that a Day Hospital not only provides therapeutic help for patients and support for their families, but also achieves earlier discharge by more efficient after-care. It may also avoid the necessity of in-patient investigation and treatment in some cases. At New Cross, some patients are treated as Day Patients in the rehabilitation and admission wards and although this overloads the staff and increases the number of patients in the ward, it allows a certain additional service to patients. This method has anticipated

the very real need which a Day Hospital will provide. Similarly, the filtering of large numbers of referrals to out-patients as seen in the above survey has amply justified the opening of an out-patient clinic two years ago.

(III) *Ward activity.* Acceptance by the patient that he will never be fit for discharge is an important cause of delay in bed turnover. An attitude of hopelessness to the problems of rehabilitating the elderly has been responsible for the passivity and drabness of many chronic sick wards of the past. The most important special facility a geriatric unit has to offer is the activity and atmosphere associated with rehabilitation. To provide this, adequate staff are required who are interested and enthusiastic, as well as educated in teaching old people how to walk, how to communicate with one another, and how to take up again the basic tasks of looking after themselves. Apart from trained staff, lay helpers and voluntary helpers can be used, and they comprise part of the present team at New Cross. The Art class in the hospital, started in March, 1966, has demonstrated how well these patients can respond to creative activity.

CONCLUSION

To provide an adequate and rapid response to present demands, the geriatric department would require an increase in beds. Apart from this, a better service will be offered by the further development of other facilities. These include the nursing and ancillary staff to carry out rehabilitation, diversional and occupational therapy activities in the wards. Out-patient services, especially a Day Hospital, will be particularly useful. The increasing demand for the latter has been shown by the swelling number of Day Patients already dealt with by the wards. It is anticipated that as the service improves the demand will also grow.

The activities of a geriatric department extend far outside the hospital walls, and its activity or lack of development are reflected in many other hospital and community services. Some of the factors external to it, and within the unit have been discussed in relation to promoting improvements in the management and discharge of patients. It is important that medical, nursing and ancillary staff should be educated and orientated towards these forward-looking ideas in relation to old people. Although morbidity and sickness are the common factors underlying admission to a geriatric unit, this survey and many others have shown that much useful remedial work can be done. Not only attitudes but also practical points of diagnosis, treatment and rehabilitation have to be taught at the bedside in the geriatric wards. It is against the background of this educational need that this survey has been presented.

A MONTH AT QUETTA HOSPITAL

by

Brian Harrison

"Get rid of that fly, please"—in the middle of an operation for the removal of a cataract, and a theatre orderly went off to fetch the fly swat hanging on the wall. On the other operating table the last patient was having his eyes bandaged, and outside the next, a Pathan tribesman was waiting his turn. Cataract and other eye diseases, notably trachoma, are extremely common in West Pakistan, and each week Dr. Holland and his assistant, Dr. Luther, have a list of perhaps fifteen patients with cataracts.

The C.M.S. hospital at Quetta was founded at the end of the last century on the tribal North West Frontier, of what was then India. Quetta is the largest town in Baluchistan, a province in West Pakistan 13,000 square miles larger than the British Isles. The town is the meeting place of Pathans from the mountainous North, and of Baluchis and Brahmins from the South. All these tribes speak fundamentally different languages and in the hospital eight languages are in common use.

Purdah still has a very strong hold upon the Moslem middle classes and for this reason male and female patients are nursed apart in two separate wings of the hospital by staff of their own sex.

Besides the eye cases a great deal of general surgery is undertaken at the hospital; gastrectomies, removal of kidney and bladder stones, thryroidectomies, operations for cancer and tuberculosis, appendicectomies, tonsillectomies and haemorrhoidectomies. More specialised plastic surgery is also performed for extensive burns, gunshot wounds and congenital abnormalities. It is also not unknown for unfaithful wives who have had their noses cut off by their husbands to come into the hospital to have then put on again. In addition to this huge variety and quantity of surgery, the commonest medical cases in the hospital are patients suffering from malaria, typhoid and tuberculosis.

These patients often have to travel many miles into Quetta from their villages. They are usually accompanied by relatives who live with the patient in hospital, either in a private ward or in the hospital

compound if the patient is in a public ward. Relatives make bread and cook rice dishes for the patients and help to look after them generally, which helps the nursing staff enormously. It also makes the monthly bill for disinfectant enormous. Women are often seen removing lice from one another's hair.

Partly because of the distances some of the patients have to travel and partly because of a Moslem fatalism, many of the cases are beyond help and many others require long and protracted treatment. People are relatively very cancer-conscious in this country. In Quetta, we saw men and women with huge ulcerating epitheliomas of the foot and mouth and a lady with a tumour on her orbit the size of a large orange which had been developing for months or even years.

The hospital staff is mainly Pakistani. Dr. Holland is assisted by three Pakistani doctors, one man and two ladies who are concerned almost entirely with gynaecological and obstetric cases, since women refuse to consult male doctors in these matters. Other Pakistani staff include two dispensers, a laboratory technician and male and female nurses, both training and qualified. There are two English nursing sisters.

Four of us drove out to Quetta in the long vacation of 1963 and spent the month of August at Quetta Hospital. This is one of the busiest seasons in the hospital since tribespeople and many town dwellers migrate up from the plains in the summer, when temperatures rise into the 130's, to Quetta which, at 5,500 feet has a much pleasanter climate.

We all had an unforgettable and extremely valuable month in Quetta. We had a glimpse of the enormous quantity, quality and variety of work which is done in this hospital, of the enormous quantity still to do and of the opportunities for all grades of medical, paramedical and research workers. Dr. Holland, who is an extremely entertaining speaker, will be talking, with slides, about his work in Pakistan on Tuesday, July 4th, to the Pupils' Physical Society, and all students, doctors, nurses, physios and radiographers who are interested would be very welcome.

OBITER DICTUM

Ex-Guy's patient, now enjoying the comparative peace of a small, provincial hospital: *I like it better here. The Sisters are much more laxative with the patients.*

90 Years Ago

From Passim June, 1877

The development of nerve and muscle can go on perfectly well side by side with the development of brain tissue, and it is well known that many on the staff of London Hospitals now, were once famous in athletics.

From Passim June, 1877

The expenditure in drugs last year was enormous, far exceeding any previous year. Another fact may also be mentioned, that some sixty thousand out-patients are prescribed for every year, and about forty thousand of them by Assistant-surgeons' Dressers, while the number of surgical cases under treatment in the wards during the year is usually about three thousand.

50 Years Ago

From Passim June 30th, 1917

One of the Medical Ward Sisters has sent us the following remarkable epistle received by her:—

"i have just seen my brother's gost is he ded. Will you Please answre can't write mor feel to bad just now."

Strange to relate, the brother in question died in the Hospital exactly twenty-four hours before the time the letter was posted. The lady who wrote the letter had not been up to see her brother for a fortnight, and there is no reason for thinking that she knew that he was likely to die at the time at which she wrote the letter.

From Passim June 16th ,1917

As there is no reason for hoping that we have seen the last of daylight air raids, it is not too late to make arrangements whereby a sufficient but not excessive number of dressers should be on duty in the Surgery while others might be told off for work in the various operating theatres. The services of first and second year students could be made use of as porters.

By Hector Cameron June 16th, 1917

In addition to the present department for Children's Diseases, there is required the establishment of a Centre for Infant Welfare, including a department for the care of pregnant women on our Charity, a school for midwifery, and a school for workers in infant welfare.

From Passim June 30th, 1917

We do not know who are the authorities responsible for the Ward Appointment list for the months of July, August and September, but in several details their selections have aroused considerable interest. In the first place it will be noticed that the numbers of Full Surgeon's Dressers are very unequal on the different firms. Sir Arbuthnot Lane and Sir Alfred Tripp rejoice in the possession of four dressers each, Mr. Steward has three, and the unfortunate Mr. Dunn has to do his best with only two. The reasons for these discrepancies are not easy to find, for it is well known that on Sir Arbuthnot's firm the work, so far as dressings are concerned is, as a rule, comparatively light and we cannot suggest any reason why Sir Arbuthnot's firm should have double the number of dressers allotted to Mr. Dunn. Again, the selections for the Special Appointments are remarkable for the fact that several students have been selected to do appointments which they have already done once or are now doing during the present three months.

From an article on the Dental Department June 30th, 1917

Students left (i.e. working in the Dental Department) can be classified as follows: South Africans, 11; Irishman, 1; other nationalities, 3; discharged, 3; unfit, 6; under age, 3; house surgeons, 3; liable for service any moment, 20.

CORRESPONDENCE

George Hayes

SIR,—To read of a stranger's death is, at the most, a reminder of the mortality of Man. To the Guy's of to-day the report of the death of George Hayes, in the last issue of the *Gazette,* will be just such an acceptance. Yet how can the cold, thin print of words stand up to the warmth of stature of such a man as George.

I first met George at Guy's some twenty-six years ago. I was a Premedical Freshman and George was studying for his 2nd M.B. In those days the pre-clinical students were evacuated during the early days of the war to Tunbridge Wells and housed in Hostels. It was at No. 5 Sandrock Road, I had the privilege of first meeting George.

It is difficult to say at what precise moment friendship starts, but I can remember being attracted by George's great fund of kindness, warmth of generosity, and his encouragement. All this given freely to a callow young freshman rather out of his depth in a much older student household. Perhaps, too, it was the fact that in George was born a gentleness of nature from which sprang a charm of manner and natural good manners the world so sadly lacks to-day. He was universally liked and strangely enough respected. I say "strangely" because in student bodies real respect in the form it was shown to George was rare.

Later we shared a room together and talked half the nights away on life in general, our ambitions and the other topics common to medical students. George never professed great longings to be a Harley Street surgeon or one of the grand old men of the academic world. His whole life was devoted to being just a good doctor. Plymouth was lucky to receive the realisation of that ambition. Even in those days the kindness of his make-up came through, for looking back on all our talks I cannot remember George being unkind about anyone.

His thoughtfulness for others shines out from one of my own experiences. I had met his lovely wife, June, before they were married. After they were married the pride in her closeness and in his family often struck me from his letters. Then I got married and with family responsibilities George and I went our own ways. I became ill and was in hospital near Bristol for nine months. One day, without any warning, through the ward door walked June and George to give me the most pleasurable surprise of my life. They had both made the long journey from Plymouth just to cheer up an old friend they had not seen in years. Any doctor will know, in a hard worked practice, how precious his free time is, and for George to have given up those hours of freedom just to stay with a sick friend for an hour or two, they will appreciate the real kindness that was George.

In the formative years of early adolescence all those who make an impression on one must leave a little of themselves behind. I like to think that in all those that loved him a part of George still lives. He lives in me .

Charles Lamb wrote George's Epitaph a long time ago, "I have not met up with anyone, nor could I meet up with anyone, who can compensate me for the lack of your society".

Yours, etc.,

B. WOTTON

Frangipani,
Roman Road,
Bleadon, Somerset.

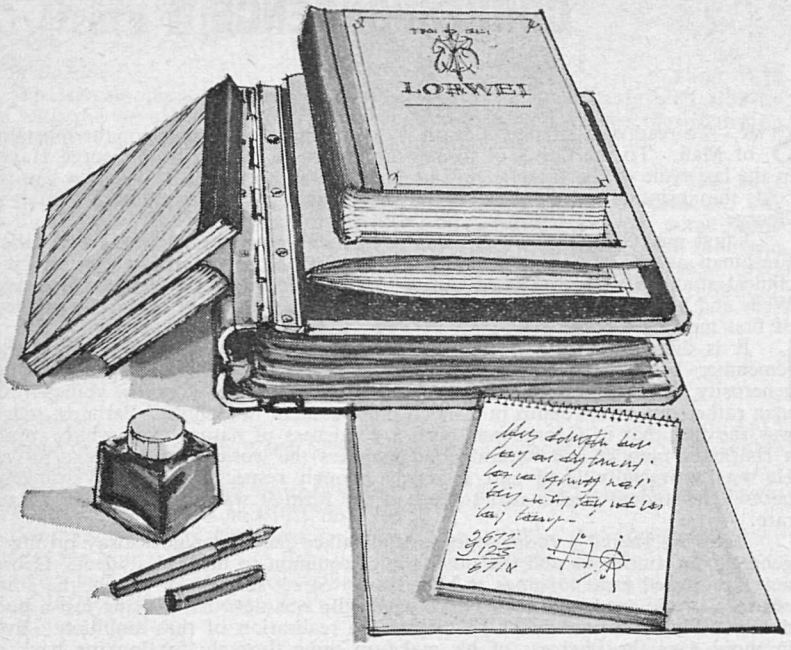
Stargazing

SIR,—If the choice is between Star-gazing and money-gazing there is much to be said for the former; it is well to remember that between the worship of God and the worship of gold there is the "L" of a difference.

Yours, etc.,

H. ST. JOHN RUMSEY

15, Wilbury Gardens,
Hove 4, Sussex.



When you've plenty to think about a bank account makes life easier

You want your grant or allowance to go as far as possible, but you don't want to spend too much time worrying about it. And you needn't. A Lloyds Bank account helps you keep an eye on your spending - you plan your payments when you pay by cheque. You don't need to carry unnecessary amounts of cash around with you. And you have regular statements of account so you always know where you stand. Call at your local branch today.

Let Lloyds Bank help you to plan

"Hang It All."

SIR,—Many of your historically sentimental readers will no doubt be pleased to know that Bright Ward now possesses a small portrait of its namesake, Richard Bright.

This little tribute, coinciding, as it does, with the commencement of kidney transplantation at Guy's, is perhaps long overdue. However, its payment was not without style.

When the picture (diligently prepared by the Medical Illustration Department) was ready, it was submitted for inspection and rubber stamping to the powers that be. As Hurst, William Gull, and Wilks Wards had similar portraits, this was thought to be a formality, but alas, not so. For although having escaped from the fortress of Matron's office, suddenly, in the Department of Interior Decoration, it was declared unfit to be hung in the open wards on the grounds that it might cause cross-infection.

Those concerned with its hanging rapidly realised that they would get thoroughly lost in the Sargasso sea of red tape if they did not act swiftly. A letter was obtained from the head of the department of Clinical Pathology stating that it was not a very serious danger. But the Superintendent's assistant declared it too high politics for him to permit without referral to higher authority. Fortunately, however, the Superintendent said it could be hung without asking permission of the Governors. Then it was duly blessed by all other parties concerned and all was ready for the Works Department. The carpenter answered the 'phone "Hanging a picture? Oh . . . Well, that'll have to wait a week mate." It did.

Yours, etc.,

M. F. D'SOUZA

94, Plaistow Lane,
Bromley, Kent.

The Point Still Missed

SIR,—I am rendered almost speechless by Allister Vale's letter in your last issue. Surely he missed the whole point of David Boulton's letter.

As I understood it, Boulton was pleading for a more humanistic, and consequently a less idealistic approach, to the moral problems of to-day. I don't think he was encouraging our sons and daughters to spend their lives indulging their every whim and fancy. He was merely indicating that those who deem it wise to be their own judge, should not be made to feel their lives have come to sad and sticky ends—as the church would have them believe—but that they have merely indulged their human frailties. As A. S. Grimble postulated—it is surely more healthy for the present generation of males to be "able to indulge in coitus with girl-friends instead of prostitutes".

Boulton is right—society today has a "less mealy-mouthed approach to the sexual practices in which most of society indulge". If Vale ever enters general practice, he may well come into contact with a very large number of people whose lives have been almost ruined by the accusative, self-righteous, holier-than-thou attitude of the church, echoed by society. The sooner this body realises that we, no less than it, can never attain perfection, the sooner may the lives of these unfortunates become more bearable.

Finally, has Vale had much contact with church-founded organisations for unmarried mothers? My experiences with such lead me to the conclusion that the condescending attitudes of these authorities do not help a person in distress at all.

Be practical, Vale. Your attitude is very commendable, but as Boulton says, "it doesn't fit the facts of society".

Yours, etc.,

RICHARD WAKELAND

Cranbrook,
Westerham, Kent.

Sister Mabel A. Chittock, M.M.

SIR,—In a recent conversation I had with Miss MacManus some few weeks ago, she happened to mention that she had been having a roam around and had discovered some medals of Sister Chittock's which were in the Revelstoke Library. One of these happened to be the Military Medal. I was most interested in this, because it was a medal awarded to Nursing Sisters for courage in the First World War, and in fact, there were only *eight* awarded in the whole of that war to the Sisters (and I happened to know one of them, who is still alive aged 90).

Miss MacManus suggested I ought to go and have a look at these; she herself told me that she remembered Sister Chittock as Home Sister when she was at Guy's.

Several days after this conversation I went to the Nursing School and asked to see these medals. This caused a bit of a "flutter" as nobody appeared to know anything about them. However, I went with a Sister who was determined not to be beaten by this quest of mine, but she herself had to enquire several times before we discovered where they were—which was on a ledge in, I suppose, the Revelstoke Library.

The extraordinary part is that I have spoken to quite a few members of the Hospital who have been at Guy's quite a number of years and even they have not heard of Sister Chittock or the medals which are at the Hospital.

I was so interested in this matter that I wrote to the War Office and have got a copy of the Citation which reads:—

Military Medal
Asst. Matron Mabel Chittock
St. John's Ambulance Brigade Hospital

For gallantry and devotion to duty during an enemy air raid. She displayed great presence of mind, and instilled courage and confidence throughout a very trying time.

The odd thing about the citation for some reason it does not mention that Sister Chittock was in the Q.A.R.N.N.S./R. which she obviously was.

Yours, etc.,

F. J. PITTS

7, De Montfort Road,
S.W.16.

Midsummer Ball

SIR,—We very much regret having to cancel this Ball, which was to have been held on the 23rd June. The reason for this is that there was not sufficient support. Up to one week before the Ball we had sold 70 of the 175 tickets. To break even we would have had to have sold 160 tickets, which were reasonably priced at 30/- a double.

We regard having to take this decision as unfortunate but had no other course open to us, being faced with a loss of over £100.

The date may well have been inconvenient to some people but we hope that if we try putting on a winter ball there will be a lot more support. We still firmly believe that there is a place in the Hospital social life which can be filled by occasions such as these.

The Entertainments Committee is trying to broaden and enlarge Guy's social life. We receive no grant for this at present. We rely entirely on your support, a necessary component in any social life.

Yours, etc.,

P. R. HUNT
pp. Entertainments Committee

Guy's Hospital Students' Club,
Guy's Hospital, S.E.1.

Hindered by Bad Light?

SIR,—We feel that the Sports Editorial should be a true reflection on the performances of the various clubs. Fair criticism is, of course, acceptable; but in the last edition of the *Gazette*, the Sports Editor made some sweeping and unjustified remarks about the Cricket Club. Surely he should make himself aware of the facts before embarking on this type of criticism; it appears that he was writing in complete ignorance.

The Cricket Club now has a strong fixture list, and up to the time of the editorial in question had won more matches than had been lost—the record now reads: played 12, won 4, drawn 5, lost 3. We are in the process of trying to improve our fixtures still further; the *Gazette* is a widely read publication, and it will do the Club no good at all if prospective opponents read that "at present, cricket spells collapse for Guy's".

We hope that in future the Sports Editor will write his Editorials with more competence and in less ignorance.

Yours, etc.,

M. I. APPLEBY
J. R. K. BUTCHEY
R. J. BEACHAM
R. K. F. CLARK
(*Cricket Club Committee*)

East Wing,
Guy's Hospital.

SIR,—With regard to the sports editorial of your last issue, may I suggest that the Sports Editor either looks up again his cricketing records or, more particularly, shows a little understanding and appreciation of the game before he again chooses to "slate" the Cricket Club so readily.

Apart from the total inaccuracy of many of his remarks, it would appear that he has not watched any of the Club's cricket this season. For, so far, the games have been hard fought and of a high club standard. Some good wins have been achieved and the matches have been much enjoyed by all concerned.

To new members especially this editorial comes as a very disheartening and ill-deserved criticism.

Yours, etc.,

DAVID CRAFTS

Guy's Hospital,
S.E.1.

SIR,—I would like to point out to your readers that contrary to what your Sports Editor said in your last edition, Guy's Cricket does not spell collapse, and we have by no means a weak side.

Our record for the beginning of the season has been a good one and we have only lost two matches, one against Honor Oak Cricket Club (which incidently your sports editor refers to as H.O.P. Cricket Club) and the other against St. Thomas's Hospital in the semi-final of the cup.

Words fail me when I describe the reaction of the team to the last sports editorial. The writer clearly understands nothing about the game, has not seen a single day's cricket this summer, and then takes it upon himself to criticise our every move.

In my opinion this last article is the worst of a series of poor editorials this summer and I feel that if he cannot do better than this you would be well advised to seek a new sports editor.

Yours, etc.,

D. B. A. SILK

East Wing,
Guy's Hospital.

Musical Bloomer

SIR,—I am grateful to your correspondent for his kindly criticism and appreciation of my article. Yes, I certainly made a bloomer about the "Ride of the Valkyries", in imputing to Grieg what really belonged to Wagner. As a matter of fact, it came to me in the night-watches, very soon after posting the article: I think the part of the Peer Gynt Suite which I have in mind is called "In the Hall of the Mountain King".

Yours, etc.,

G. L. DAVIES

Oakfield,
Hay-on-Wye, Hereford.

NOTICES

Registrar's Flats

Sarah Swift House in Kipling Street has flats for members of the nursing staff. Occasionally one or two of the larger ones are not taken and are available for renting by Registrars. The larger flats have either two or three rooms, plus kitchen, bathroom and lavatory; at present two are occupied by Registrars.

Mr. Loomes in the Counting House keeps a Waiting List for these flats; any Registrar wanting further information or wishing to place his name on the list should contact him.

Music Circle

An informal concert will be held on Monday, July 3rd, at 7.30 p.m. in the Nurses' Sitting Room. There will be solo piano music by Mozart and Bartok, and a selection of amorous (!) poetry and music of the Rennaissance presented jointly by the Music and Theatre Clubs.

Wine and Cheese will be served in the interval.

Anyone in Guy's will be welcome. Applications for tickets should reach the Secretary of the Music Club via the East Wing by Monday evening, June 26th.

MICHAEL COE
Hon. Secretary

Thirty Club

The annual dinner of the Thirty Club was held on Thursday, 19th May, 1967, at the R.A.F. Club. It was decided that next year's dinner should be held on Friday 17th May, 1968 at the R.A.F. Club, with Dr. G. E. Genge Andrews, O.B.E., as Chairman.

E. J. CRISP
D. J. P. O'MEARA
Hon. Secretaries.

Guy's Hospital Dental Society

The A.G.M. of the Dental Society was held on 16th May in the Dental Theatre. The President, Mr. R. O'Neil, took the chair.

In his report, the Secretary, Mr. J. W. C. Halliday said that the Society had had a very successful year. The Ball and the Dinner had both been great successes. The Society had also obtained a revision of the bur allowance. Finally, Mr. Halliday thanked Mr. O'Neil for his help as President for the past year and wished him every success in his new post as Reader in Oral Surgery at U.C.H. The twenty people present showed their appreciation in the usual way.

The following officers were elected for the coming year:

Hon. Secretary: G. M. Thomas.
Assistant Secretary: S. N. Cripps.
Treasurer: K. A. Eaton.
Ball Secretary: I. J. Mackenzie.
Assistant Ball Secretary: Miss C. A. Blanks.
Dinner Secretary: R. W. Kendrick.
Assistant Dinner Secretary: C. G. Neville.
5th year rep.: Miss C. A. Miller.
4th year rep.: R. Loomes.
3rd year rep.: A. S. Blinkhorn.
Pre-clinical rep.: R. Lane.

QUIZETTE : Cardiology

1. Is an opening snap usually present in:—

   (a) Mitral stenosis; (b) Mitral incompetence; (c) Tricuspid incompetence; (d) tricuspid stenosis; (e) aortic stenosis?

2. Which of the following may be used to judge the severity of mitral stenosis?

   (a) Loudness of the mitral diastolic murmur; (b) Presence of an opening snap; (c) The length of the mitral diastolic murmur; (d) The interval between the second heart sound and the opening snap; (e) Loudness of the first sound.

3. D.C. Countershock is an effective treatment of:—

   (a) Atrial fibrillation; (b) Ventricular tachycardia; (c) Ventricular fibrillation; (d) Digitalis-induced atrial tachycardia; (e) Complete heart block.

4. *Reversed splitting of the second sound may occur in:—*

   (a) A.S.D. (atrial septal defect); (b) P.S. (pulmonary stenosis); (c) L.B.B.B. (left bundle branch block); (d) Ischaemic heart disease; (e) Cardiomyopathy.

5. Wide splitting of the second sound usually occurs in:—

   (a) A.S.D. (atrial septal defect); (b) Fallot's tetralogy; (c) R.B.B.B. (right bundle branch block); (d) Pulmonary hypertension; (e) Mitral stenosis.

6. Which of the following is a normal response or value in a normal subject?

   (a) A fall in cardiac output when changing from a supine to an upright position; (b) A pulmonary artery pressure of 25/10mm. Hg.; (c) A higher flow through the upper lobe than the lower lobe of the lung; (d) An unaltered pulse pressure during a Valsalva's manoeuvre; (e) A left ventricular and diastolic pressure of 5mm. Hg.

7. A mid-diastolic murmur may occur in:—

   (a) Aortic stenosis; (b) Aortic incompetence; (c) Atrial septal defect; (d) *Ventricular septal defect*; (e) *Acute rheumatic fever.*

8. Complete heart block is:—

   (a) Most commonly due to ischaemic heart disease; (b) May be treated by Propranolol; (c) May be treated by Saventrine; (d) Cannot occur in the presence of atrial fibrillation; (e) Urgently requires the insertion of a cardiac pacemaker as soon as it is diagnosed.

9. Stokes Adams Attacks

   (a) Only occur with permanent complete heart block; (b) Are always due to Ventricular arrest; (c) Are always due to ventricular fibrillation; (d) May be due to both ventricular arrest and ventricular fibrillation; (e) May be controlled by Isoprenaline.

10. Which of the following may be caused by a giant left atrium?

    (a) Dysphagia; (b) Hoarseness; (c) Horner's syndrome; (d) Pain in the back; (e) parasternal heave.

11. Syncope may be the presenting feature of:—

    (a) A pulmonary embolus; (b) An atrial myxoma; (c) Aortic stenosis; (d) Complete heart block; (e) Myocardial infarction.

12. The following are electrocardiographic features of hyperkalaemia:—

    (a) Tall pointed T wave; (b) Shortened PR interval; (c) Widening of QRS interval; (d) Prominent U wave; (e) Ventricular fibrillation.

QUIZETTE ANSWERS

We would suggest, as the answers may for reasons of space be printed rather closely together, that readers answer all the questions before checking on the answers. We appreciate that the test is considerably more difficult this way.

1. **a d**

An opening snap is usually present in mitral stenosis and tricuspid stenosis but does not usually occur in mitral incompetence, tricuspid incompetence, and never occurs in aortic stenosis.

2 **c d**

The severity of mitral stenosis may be assessed by the length of the mitral diastolic murmur. It has, of course, got to be related to the length of diastole. A long diastole which is completely filled by the mitral diastolic murmur, is of course much more significant than the complete filling of a short diastole. The interval between the second heart sounds and the opening snap may also be used to assess the severity of the mitral stenosis. If this interval is small, for example, less than .07/sec. then it suggests that the mitral stenosis is severe. The other points mentioned are of no value in assessing the severity of mitral stenosis.

3. **a b c**

D.C. Countershock is an effective treatment for atrial fibrillation, ventricular tachycardia and ventricular fibrillation but is contra-indicated in digitalis-induced atrial tachycardia because it is liable to precipitate ventricular fibrillation and of course it has no place in complete heart block.

4. **c d e**

Reverse splitting of the second sound may occur in left bundle branch block ischaemic heart disease or cardiomyopathy but not in an A.S.D. or pulmonary stenosis. It occurs in conditions affecting the left ventricle.

5. **a c**

Wide splitting of the second sound usually occurs in A.S.D.'s and in right bundle branch block. The second sound in Fallot's Tetralogy is usually single. The second sound in pulmonary hypertension is usually closely split and in mitral stenosis normal unless there is pulmonary hypertension in which case it would be closely split.

6. **a b c**

A fall in cardiac output occurs on change from a supine to an upright position in a normal subject. A pulmonary artery pressure of 25/10 is normal and left ventricular and diastolic pressure of 5mm. Hg. is normal. The flow is normally less through the upper lobes than through the lower lobes of the lungs, and the pulse pressure is normally considerably diminished during a Valsalva's manoeuvre.

7. **b c d e**

A mid-diastolic murmur may occur in aortic incompetence (Austin Flint murmur), atrial septal defect (a tricuspid flow murmur), a ventricular septal defect (mitral diastolic flow murmur) and acute rheumatic fever (Carey Coombs murmur). It does not occur or course with aortic stenosis.

8. **c**

Complete heart block is most commonly due to a non-specific inflammatory or degenerative lesion of the conduction tissues and not most commonly due to ischaemic heart disease although it does occur with ischaemic heart disease. It may be treated by Saventrine which is long-acting Isoprenaline and can occur in the presence of atrial fibrillation. Unless the patient is having Stokes-Adams attacks there is no urgent reason to insert a cardiac pacemaker. Propranolol has no place in the treatment

9. **d e**

Stokes Adams attacks may occur with intermittent heart block and may be due to both ventricular arrest and ventricular fibrillation. They may also be controlled with Isoprenaline.

10. **a b c**

A giant left atrium may cause dysphagia due to pressure on the oesophagus, hoarseness due to pressure on the recurrent laryngeal nerve and pain in the back but does not cause Horner's syndrome or a parasternal heave.

11. **a b c d e**

Syncope may be the presenting feature of pulmonary embolus, an atrial myxoma, aortic stenosis, complete heart block and myocardial infarction.

12. **a c**

Hyperkalaemia causes tall pointed T waves and a widening of the QRS interval, does not cause a short PR interval. Prominent U waves are a feature of hypokalaemia and not hyperkalaemia. If the hyperkalaemia is severe, the heart will arrest in asystole but not ventricular fibrillation, and so ventricular fibrillation is not a feature of hyperkalaemia.

Compiled by D. C. FLUCK.

NURSING SECTION

Nurses' Clubs

The advantages of community life are many, and notable amongst them are the facilities offered by group membership in interesting concerns. The disadvantages are also many but one of the biggest amongst the nursing community is that of total lack of interest by all except a very few in combining together to form groups with the same hobbies or interests.

Apathetic is the adjective which can be used to describe nurses' response to anything which is offered to them and unless it is handed out on a plate, very little interest is taken.

I am referring, of course, to the difficulty experienced by anyone who is attempting to get nurses to join anything extra mural or to carry out any off-duty tasks which require a little of their ever-increasing free time.

Why is there such a lack of interest amongst the nursing staff? They ask to be included in a few student activities but do not seem to be prepared to go the half-way necessary to forming union with the students.

Admittedly, politically the nurse cannot join the students' union, but there is no reason why they should not form a sub-union of their own, or a type of entertainments committee. In this way, by payment of a minimal annual subscription they could well be accepted as affiliated members to some of the students' activities. To state one example—the present gathering of "Inflam" could be made available to the nurses as partly their responsibility, and they would be made members by production of a card on entering the gathering.

Student club activities might be made open to nurses who had already formed their own small clubs. The present nurses' clubs are limited to Music, Swimming and Tennis, but there are many more students' activities which are of interest to the student nurses—for example photography, the art society, fencing, squash club and so forth.

The difficulty in forming nurses' clubs is that they are reliant on fixed hours of freedom, but there are enough student nurses to make sufficient members of any number of clubs. There are also plenty of nurses with good organising talents who could get the whole thing swinging and also gain the interest of the medical and dental students.

With this wealth of talent available amongst the ranks of the nurses, there must be many people who are willing to assist in raising the nurses out of their apathy and create more hobbies for them.

STAFF CHANGES AND APPOINTMENTS

APPOINTMENTS

S/N E. K. Stauter (Harper Hospital, Michigan) to Renal Dialysis Unit.

RESIGNATIONS

Sister D. N. Parsons from Hector Cameron Ward Evelina Hospital

C/M R. M. Sanders from Victoria Ward.
C/N V. Yates from Psychiatric O.P.D.
S/N M. Cracknell from Evelina Ward.
S/N M. Burton from Esther Ward.
S/N M. Rushforth from Casualty Department.

OBITER DICTUM

Sister in Salomon's Centre to rather prim, trim and exceptionally slim spinster: "*You know, this is the ante-natal clinic.*"

Spinster: "*Indeed it is not! I have an appointment in the Venerable Clinic.*"

SPORT

CRICKET

A mid-season weekend "tour" to Dover rewarded Guy's with a fine win over their strongest opponents of the season—a combined St. Lawrence and Highland Court XI. Guy's batting first declared at 167-9 with Silk contributing 52. In reply St. Lawrence and Highland Court scored a total 108, being thwarted by fine bowling from David Crafts whose final tally was 7-49.

The first game of the weekend against Dover provided the cricketers with an exciting finish. Guy's were unlucky not to prevent Dover (replying to Guy's total 147) from winning in the closing moments of the game with 148-9—in spite of a good bowling performance from Crafts with 6-63.

Returning to London, Guy's on the following weekend played Teddington. Although a strong fixture, Guy's were unable to repeat their victories of previous seasons and the match was drawn. A similar result was obtained from playing Hampstead on the following day. Hampstead scored 188 (Monro 104) with C. Pearson for Guy's taking 7-74. Guy's in reply gathered 126-9 (Appleby 46, Chase 24) and with their 10th and 11th batsmen at the crease played for the draw. It is worthy of note that Beacham opened his scoring for the season.

ATHLETICS

Already University Champions for this season, the Athletics Club has added to its trophies the United Hospitals' Shield. With 11 hospitals competing, Guy's gained five 1st places:—
J. Domaingue, 120 yds. hurdles; I. Morgan, 440 yds. hurdles; D. Choat, 880 yds.; G. Edwards, hammer; A. Ross, Weight.

The Cup for the Tug-of-War competition was proudly carried to Guy's with a team consisting of 1st. XV players. The best track performance of the day was awarded to Ian Morgan.

We warmly congratulate Ian Morgan on becoming British University Champion in the 440 yds. hurdles, when on Saturday, 17th June, in the British University Championships, he returned a time of 53.4 secs. (despite hitting the seventh hurdle)—0.4 secs. faster than his closest rival, D. Scharer (Oxford), the holder.

However, he desparately needs a faster time in the forthcoming A.A.A. Championship to be considered for a place in the British University Team competing in the World University Championships at Tokyo in August.

DIARY

CRICKET

June 24.—Past v. Present, 11.30 a.m. H.
June 25.—Mad Hatters, 2.00 p.m. A.
June 28.—Queens Belfast, 2.00 p.m. H.
July 1.—Mote, 11.30 a.m. H.

ATHLETICS

UNITED HOSPITALS' CHAMPIONSHIPS, 1967

Result: Guy's won

Having won the University Championships at the beginning of the season, and the United Hospitals' field events and relays competition three days before, we started these championships with high hopes of success.

The afternoon was very warm and there was no wind, so that good performances were expected; in fact, only one record was broken. From the first results that were announced it was clear that Guy's was moving into the lead. Once again this was not because of the number of wins but because we managed to enter two people in each event—we had a strong team of 16 people.

In the field events A. Ross, G. Edwards, and R. Bailey all gained valuable points for us; the first two mentioned both won cups. The track events started well for us as both our competitors in the 440 yards hurdles and the 100 yards were through to the finals. Our first win on the track came from J. Domaingue who hurdled with a very smooth style to victory in

the 120 hurdles. Three false starts for the 100 yards final had all the spectators (and the competitors!) on their toes in expectation of a very exciting race: no disappointment for the crowd. F. Nwator held his place all the way, but having been beaten off the blocks, could not pull up to win; D. Barford, still being troubled by a pulled muscle, was unable to produce the power for the finishing burst. Their places—2nd and 4th—gave us a lead in points in this event. In the 220 yards Mitchelle, from the Royal Vets, broke the United Hospitals' record to win from D. Barford, our second string in this event, who also scored in the final—once again giving us a win on points.

In the middle distance events, congratulations to J. Harrild who ran his first steeplechase race ever and came through to sixth place with a strong finish. T. Fallowfield recorded his fastest time this season for the half-mile.

Undoubtedly the track honours go to I. Morgan who had an extremely demanding afternoon, having to run four 440 yards. His last one of the afternoon was the 440 yards flat which he won in 49.3 seconds, only 0.1 outside his personal best for this race. In the 440 yards hurdles his time of 53.9 seconds was not good by his own standards, but by U.H. standards it was the best track performance of the afternoon.

A tug-of-war competition was also held during the afternoon. Unfortunately, only *three hospitals entered for this.* Guy's, being the champions from two years ago, were given a bye in the first round so they were able to start the final as a fresh team. Their opponents had already pulled in one round. Guy's team remained champions.

Results

100 yds.—2, F. Nwator, 10.2 rsecs.; 4, D. Barford, 10.5 secs.
220 yds.—2, D. Barford, 23.3 secs.; 4, J. Price.
440 yds.—1, I. Morgan, 49.3 secs.
440 yds. hurdles.—1, I. Morgan, 53.9 secs.; 4, P. Bundred.
880 yds.—1, D. Choat, 1 min. 58.5 secs.; 4, A. Fallowfield, 2 mins., 3.9 secs.
3 Miles—5, J. Harrild.
2,000 m. steeplechase—6, J. Harrild.
120 yds. hurdles—1, J. Domaingue, 16.6 secs.
L.J.—1, 5, J. Domaingue, 20 ft. 4 ins.: 6, M. Bates, 19 ft. 0 ins.
P.V.—1, 2, G. Edwards; 4, P. Bundred.
Weight—1, A. Ross.
Discus—2, G. Edwards.
Javelin—3, G. Edwards.
Hammer—1, G. Edwards; 6, R. Bailey.
4 x 110 yds relay—2, Guy's.
Medley relay—2, Guy's.
Tug-of-war—1, Guy's.

GUY'S v. MIDDLESEX v. LONDON

Wednesday, June 7th, 1967

Result:

eq 1st, Guy's and Middlesex, 79; 2, London, 74

Fine weather and teams being nearly equal numbers promised to provide an enjoyable afternoon; none of us was disappointed.

G. Voss and T. Higgenbottom gained most points for Guy's and showed great versatility by competing in the 100 yards, 220 yards, shot, discus, javelin, and long jump. T. Fallowfield ran very well in the mile to win, and also came a close 2nd in the half-mile. D. Barford ensured a win for us in the 4 x 110 yards relay, gaining several yards on the anchor leg.

A very close and enjoyable match, as the score witnesses.

Results

100 yds.—2, Higgenbottom; 5, Voss .
220 yds.—2, Higgenbottom; 4, Voss.
440 yds.—1, Barford; 3, Choat.
880 yds.—1, Choat; 2, Fallowfield.
1 Mile—1, Fallowfield; 2, Smith.
L.J.—5, Higgenbottom, Voss.
Shot—3, Voss; 4, Higgenbottom.
Javelin—4, Voss; 6, Higgenbottom.
Discus—1, Voss; 5, Higgenbottom.
4 x 110 yds. relay—1, Guy's.

CRICKET

GUY'S v. DOVER

Saturday, June 3rd, 1967

Guy's: 147. (Penn, 5—50.)
Dover: 148—9. (D. Crafts, 6—63.)

This game was one of the more exciting games so far this season, finishing with a result in the last minute.

Guy's batted first, scoring 147 all out. A moderate score, due to the fact that no two batsmen seemed to be able to stay together long enough to affect a long stand. In fact, no batsmen scored above 30. A. Pearson, batting in the unaccustomed position of No. 11, amazed everyone with two enormous hits for six into the pavilion.

Dover were left plenty of time in which to get the runs, but good opening bowling by Crafts and Beacham put Guy's back into the game. Crafts bowled particularly well, finishing with 6—63 in 21 overs. Unfortunately for Guy's, Dover put on 40 runs for the eighth wicket and although we captured another wicket they were able, with only a minute to spare, to pass our total.

GUY'S v. ST. LAWRENCE AND HIGHLAND COURT

Guy's: 167—9. (Silk, 52.)
St. Lawrence and Highland Court: 108. (Crafts, 7—49.)

Highland Court and St. Lawrence, amalgamated this season, are definitely the strongest club that we play. This win by 59 runs was very satisfying. Highland Court won the toss and put Guy's into bat on a wicket likely to assist seam bowling. Once again we failed to make a satisfactory start, and it was left to Clark and Chase to build up a good start to the innings. They batted most of the morning, scoring slowly, with the result that at lunch the score was 53—2. It was important, however, that although only a few runs were scored in the pre-lunch session, that Highland Court did not capture as many wickets as they hoped. After lunch Clark was out and Silk began to push the score along a bit faster, scoring a very good 52. Guy's were then able to declare at 167.

Highland Court batted for 20 minutes before tea, loosing two wickets for four runs. After the tea interval they failed to recover, although their last two batsmen stayed stubbornly until ten minutes from time. Once again we saw David Crafts bowling at his best. He bowled unchanged for the second time this week-end and finished with 7—49 in 23.3 overs.

This game was a very good finish to a very good week-end cricket.

GUY'S v. TEDDINGTON

At H.O.P. Saturday, June 10th

Result: Drawn

Teddington are currently one of the strongest London sides; indeed Guy's were the last team to beat them, and that was exactly a year ago. In view of this, they produced a really powerful side who had the the better of a high-scoring draw.

Teddington had first use of a perfect batting wicket, and took full advantage of their luck

to score 191-2 declared. On the whole, the batsmen were in command, though both Crafts and Beacham bowled well in their opening spells without having any luck. The first wicket put on 97 before Neville neatly stumped Hollands off Davoodbhoy. There other opener, Taylor, was run out for 99 by a good throw from Beacham.

Guy's were left 130 minutes to make the runs. This proved to be too great a task with Hurst, who played regularly for Middlesex only six years ago, bowling unchanged at one end. Butchey and Thompson gave Guy's a sound but slow start, and when they were both out within a few minutes of each other, their required run-rate had risen. Though the later batsmen, especially Clark and Silk, tried gallantly to catch up with the clock, Guy's in the end had to settle for a draw. The last over saw the interesting spectacle of crafts J. bowling to Crafts D. with Crafts senior umpiring!

Teddington: 191-2 dec. (Taylor 99)

Guy's: 147-7 (Clark 36, Silk 36, Hurst 4-36)

M. I. APPLEBY

GUY'S v. HAMPSTEAD

At Hampstead

Hampstead: 188. (Pearson, 7 for 74.)

Guy's: 126 for 9. (Appleby, 46; Chase, 24.)

Result: drawn

On a warm day with brilliant sunshine, we were sent out to field at Hampstead's lovely ground. Scheduled to start at 11.30, the match did not get under way until 12.00 as the home team could not find a full team.

Fortune favoured us at the start, as Beacham and Clark disposed of the opening batsmen with only two runs on the board. From then onwards, however, Hampstead gradually recovered, due mainly to their No. 3 batsman, Monro, who scored 104. Charlie Pearson bowled steadily and accurately and was aptly rewarded with the fine figures of 7 for 74.

Set to score 188 to win, Guy's started off badly, losing their first two wickets with only 10 on the board Chase (celebrating his birthday today) and Appleby batted very well before they were both out to rash strokes. With five minutes to end of play, we found ourselves with the score at 126 for 9 with our Nos. 10 and 11 in the middle. We had some very anxious moments, as Beacham played his patented forward defensive and Pearson curbed his normally attacking style. Beacham, incidentally, opened his scoring for the season with a snick to the leg—a trifle late perhaps!

The match having been drawn, the team then proceeded to celebrate Chase's birthday in no uncertain way.

J. R. K. BUTCHEY

SAILING CLUB

At the summer regattas this year the 1st VIII has been entering Junior-Senior events while the 2nd VIII has been entering Novice events, and in this way both crews have met other crews of approximately the same standard.

Chiswick Regatta. J/S VIII's

Guy's rowed on the centre station of this four-minute course, between Mortlake and Chiswick. Their opponents were Furnival Sculling Club and Imperial College. After the start Guy's were in second place behind I.C., but then both the other crews pulled away and I.C. won. The event was won by Quintin.

Brent Regatta. J/S VIII's

This was held on Bank Holiday Monday on the Welsh Harp. Guy's were on the north station and were rowing against Bedford R.C. and Latymer Upper School. Guy's and Bedford remained fairly close, while Latymer won in a fast time of 3.22.

Horseferry Regatta. Novice VIII's

The 2nd VIII made its debut here, and the results show that this spirited crew has great potential in its class.

In their first race, Guy's proved too much for the "strong arm of the law" and beat a Metropolitan Police crew by seven lengths!

In the second round Guy's did well to beat a combined University College Hospital and St. Mary's Hospital crew by 1½ lengths. In the semi-final they beat Stanley School by two lengths.

In the final, their fourth race, they met an obviously fitter Weybridge crew and did very well to keep with them for over a minute. Weybridge, however, gradually gained one length which they held to the finish. This was a very creditable performance by the Novice eight which, under the captainship of J. Skuse should do well at subsequent regattas.

Crews

1st VIII: Bow, A. Batch; 2, P. Moulder; 3, G. Stygall; 4, N. Bax; 5, A. Hodgkison; 6, J. Miller; 7, J. Pook; Stroke, R. Forrest; Cox, T. Kirk.

2nd VIII: Bow, P. Robinson; 2, R. Tudor-Williams; 3, J. Swain; 4, J. Skuse (Capt.); 5, A. Hodgkison; 6, A. Fenn; 7, N. Pinckney; Stroke, K. Sommi; Cox, R. Stanley.

GEOFFREY STYGALL, Hon. Sec.

GOLF

GUY'S v. ST. THOMAS'S

Quarter-final

This quarter-final encounter with St. Thomas's did not live up to be the close match it was expected to be, Guy's winning very comfortably in the end by four matches to one.

In the top match, D. Adams, playing against a very off-form opponent, eventually won 4/3.

Captain Peter Ellis, after a lean period, returned to form at the right time, and after level par for the first nine holes, found himself six up. This very unusual state of affairs we feared might well be to much for him; however, he proved us wrong and eventually won by 8/6.

Meanwhile, our old campaigner, Bruce Bevan-Jones, has seemingly deserted the battlefield, but fortunately was later found gaily thrashing around the deep Surrey woodland; a pleasant pastime, no doubt, but one that eventually left him three down early on. However, showing his customary stamina he still managed to take his opponent up to the eighteenth to lose his match but receive the ovation of his sympathetic comrades.

For David Elliott, the tree-lined fairways and heather rough held no fear, and hitting the ball in his customary style, his only complaint was that he found the course too short. Meanwhile, he had beaten his opponent by 4/2.

Bringing up the rear was Alan Phillips who, playing his usual steady game, eventually won by 3/1.

All in all this was a very good win and must now make us favourites to win the inter-hospitals' cup yet again.

D. ADAMS

HOSPITAL INFORMATION

APPOINTMENTS VACANT

GUY'S HOSPITAL, S.E.1.

Applications are invited for the post of **Senior Registrar in Thoracic Surgery** for a period of one year from 1st October 1967. Forms of application are obtainable from the Superintendent, Guy's Hospital, and should be returned not later than **7th July 1967.**

Applications are invited for the post of **Registrar in Ophthalmology** (two sessions per week), with appointment from 1st August, 1967—30th September, 1968. Forms of application are obtainable from the Superintendent, Guy's Hospital and should be returned not later than **30th June, 1967.**

Applications are invited fir the post of **Locum Senior Registrar in Surgery,** with duties from 30th July—30th September 1967 in the first instance. Forms of application are obtainable from the Superintendent, Guy's Hospital, and should be returned not later than **7th July 1967.**

Applications are invited for the following **Dental House Surgeon Appointments** for the period July 15th, 1967 to January 14th, 1968.

General Duties, 2 vacancies
Children's Department, 1 vacancy

Applications should be sent to the Superintendent, Guy's Hospital, London, S.E.1, not later than **23rd June, 1967.**

Candidates may apply for either of the posts and should indicate their preference.

P. J. HELLIWELL
Superintendent.

GUY'S HOSPITAL MEDICAL SCHOOL

Applications are invited for the post of **Lecturer in the Department of Surgery,** with appointment from 1st October, 1967, for one year in the first instance. Salary in the range £1,745—£2,820, according to qualification and experience, plus £60 London Allowance. Application should be made, on a form obtainable from the Dean, by **10th July, 1967.**

GUY'S HOSPITAL AND SOUTH-EAST METROPOLITAN REGIONAL HOSPITAL BOARD

Applications are invited to fill an established vacancy for the appointment of **Senior Registrar in Physical Medicine to the Board of Governors of Guy's Hospital and the South-East Metropolitan Hospital Board.** The applicants will be expected to spend two years in the region during a three-year tenure of the post. The appointment will be made jointly by the bodies concerned. The post in the Regional Hospitals will be held in the Bromley, Orpington and Sevenoaks Groups. The post, which will be reviewed annually, is subject to the Terms and Conditions of Service of Hospital Medical and Dental Staff (England and Wales) with duties commencing 1st October, 1967. Forms of application are obtainable from, and should be lodged with the Superintendent, Guy's Hospital, S.E.1, not later than **7th July, 1967.**

GUY'S-MAUDSLEY NEUROSURGICAL UNIT

Applications are invited for the resident post of **Senior House Officer,** for six months commencing mid-July, 1967. The Unit, which is housed in the Maudsley Hospital, serves both Guy's Hospital and the Bethlem Royal Hospital and the Maudsley Hospital. Applications giving details of experience and the names of two referees, should be made by **30th June, 1967,** to L. H. W. Paine, House Governor, Maudsley Hospital, Denmark Hill, London, S E.5.

GUY'S HOSPITAL, MAUDSLEY HOSPITAL, AND THE SOUTH-EAST METROPOLITAN REGIONAL HOSPITAL BOARD

Applications are invited for appointment as **Senior Registrar in Neurosurgery.** The appointment will be made jointly by the bodies concerned and will be held alternately at the Guy's-Maudsley Neurosurgical Unit and the Regional Neurosurgery Centre at the Brook Hospital. The appointment will commence on 1st September, 1967, and will be subject to annual renewal.

Applicants should have had Registrar experience in Neurosurgery and should have a higher surgical qualification.

Apply to the House Governor and Secretary, Maudsley Hospital, Denmark Hill, S.E.6, for form of application, returnable by **8th July, 1967.**

PASS LISTS

ROYAL COLLEGE OF SURGEONS IN IRELAND

Fellowship of Faculty of Anaesthetists

B. R. T. Smith

ROYAL COLLEGE OF SURGEONS, EDINBURGH

F.R.C.S.

E. M. Holt

COLLEGE OF PATHOLOGISTS

Fellowship

M. B. King A. K. Mant

UNIVERSITY OF LONDON

Ph.D.

Susan E. Young

D.Sc.

C. W. M. Adams

PERSONAL

12 MINUTES LONDON BRIDGE, at Forest Hill, 1961 Town house for sale—three bedrooms, bathroom and W.C. upstairs; living-room, kitchen and W.C. downstairs. £5,650 or near offer. Call 699 5423.

CHANGES OF ADDRESS

Dr. and Mrs. P. Banks, to Westwards, High street, Dormansland, Surrey.

Mr. G. C. W. Baker, F.R.C.S., Whittington Lodge, Old Whittington, Chesterfield, Derbyshire (Chesterfield 5795).

Mr. R. G. Beard, Consulting Rooms at 55, Wimpole Street, London, W.1. (01-935 8607).

Mr. D. J. W. Foster, L.D.S., R.C.S. Practice address: 137, Harley Street, London, W.1. (Tel: 01-935 3394).

Mr. G. F. Gibberd, 5, Tollgate Drive, College Road, Dulwich, London, S.E.21 (only address). (Tel: 01-693 2955).

Dr. F. D. Higgs, Kabarole Hospital, P.O. Box 37, Fort Portal, Toro, Uganda.

Dr. J. E. A. Knowles, 22, Elmete Way, Leeds 8. (Tel: 655414).

Dr. Rosalind Millis (née Smith), 177, Sheen Lane, London, S.W.14.

Dr P. A. D. Williams, 4, Glen Court, Abbey Road, Brighton 7, Sussex. Tel: Brighton 66155.

C. Peter Briggs, 47, Arlington Avenue, Leamington Spa.

ENGAGEMENT

PICKLES—GARDNER—The engagement is announced between Mr. Andrew Pickles B.D.S. and Miss Elaine Gardner, both of Wrexham, North Wales.

BIRTHS

ARMSTRONG—On 29th April, 1967, to Virginia (née Thompson-McCausland) and Angus Armstrong, a daughter, sister to Dominic.

PAUL—On 24th April, 1967, at home, to Caroline (née Ryan) and Robert (Bumble) Paul, a daughter, Clare Alison, a sister for Anna.

REES—On 26th May, 1967, in Gloucester, to Sandra (née Evans) S.R.N., and Hugh Rees, M.B., B.S., a daughter, Emily Jane.

REYNOLDS—On 23rd April, 1967, at Kalgoorlie Regional Hospital, Kalgoorlie, W. Australia, to Barbara (née Allen) and Dr. Richard Reynolds, a daughter, Judith Mary, a sister for Sarah, James and Matthew.

NEEDHAM—On 2nd June, 1967, to Peter and Anne Needham (née Reynolds) of 21, Nutbourne Road, Farlington, Portsmouth, a boy.

TOMLINSON—On April 18th, 1967, at Chester City Hospital, to Patricia (né Lane) and John Tomlinson, a son, James Dominic, a brother to Charlotte and David.

DEATHS

MOORE—Reginald Arthur Moore, L.D.S., R.C.S.(Eng.), on June 3rd, 1967, in Torbay Hospital.

SHELSWELL—On June 1st, 1967, suddenly at his home, Arthur Hugh Shelswell, M.R.C.S., L.R.C.P., in his 72nd year.

We would like to remind our readers that all copy for inclusion in the Gazette must be received eight days before the publication date.

Personal notices one shilling per word (Minimum £1. 1s. 0d.)
Birth, Marriage, Death and Change of Address notices are without charge to subscribers.
Non-subscribers will pay £1. 1s. 0d. for all notices other than Personal.

GUY'S HOSPITAL GAZETTE

EDITORS D. S. ROBINS and C. B. BROWN
SPORTS CORRESPONDENT J. G. PAYNE
NURSING CORRESPONDENT E. A. MALPAS

FORTNIGHTLY TWO SHILLINGS VOLUME 81 NUMBER 2060

The opinions expressed in these columns are solely those of their authors and are not to be taken as the views of the Hospital as a whole.

PASSIM

Teaching Period

". . . And you will find that this phenomenon occurs most frequently in ——". The rest is drowned in a sudden deafening noise in the form of hammering, drilling, the banging of doors by helpless patients' feet on porte-pushed wheelchairs, or by the myriads of trolleys of C.S.S.D., kitchens, pharmacy, laundry, etc. Alternatively, the all-important words are lost in competition with the unnecessarily loud voices of nurses, patients, students taking histories or houseman/housewomen walking past in loud report to consultants or registrars. And we are left with students craning their necks forward even further to catch the words which are often softly spoken anyway. An environment for learning?

Be opinions regarding bedside teaching as they may, what the student picks up at the bedside round forms an important part of his clinical education at present. The teaching hospital must inevitably produce problems of balance between teaching and the organization of hospital services. That the patient comes first is unquestioned, but teaching need not appear as far behind as some quarters would seem to have it. It may be difficult for many of us to understand how the ordinary dictates of politeness, let alone the behaviour that comes of respect, seem to be lacking in so many when they come or find themselves in the vicinity of a teaching round. Some rounds may have a sanctimonious air about them, but we cannot take all the noisy disregard to be a religious protest. We are dealing simply with conscious and/or subconscious heckling. That this is not an exaggerated picture may be amply proved by getting the dubious to attempt to silence the offenders, and to watch their reaction to the usual indignant or impatient answer, with the unseen union card being waved in the air where applicable.

Action? Firstly one must exclude the possibility that the offenders are themselves suffering from the noisiness which comes from a loss of acoustic acuity. Secondly, and more seriously, the various departments concerned could have a quiet talk to all those of their staff who have cause to visit the wards. Thirdly, and best of all, we could follow the example of Victoria Ward, where there is a daily "rest period", which is disturbed with trepidation. Could we not have a *teaching*

period on the wards? This would entail a relative peace being maintained at the most for 3-4 hours during the day, and not necessarily on every day. The organization may well require some careful planning but ought not to be dismissed without serious consideration. Plans would be facilitated by the fact that owing to the layout of the wards the problem is largely found only in Hunt's House, so that the time and effort lost in being unable to make large deliveries to medical wards at certain times, could be used in completing all those to the surgical wards. Finally, if official notices could be made for hanging outside ward doors, indicating that a teaching round is in progress they might have better effect—the present occasional makeshift notices on some wards are apparently not *official* enough for those who require such instructions to their behaviour.

Quite apart from improving the teaching environment, such a period will enable the patient's day to resemble more of what one is led to understand as being offered by the word 'hospital' in its original and literal meaning.

A Matter of Life and Life

The loaded question as to whether or not large sums of money and considerable talent should be devoted to treating only a small group of patients is one that is increasingly facing doctors, Health Ministers and Parliament.

For example, the treatment of irreversible renal failure by dialysis. Beyond the actual cost of equipment there is the cost of staffing the service and the financial loss to the family of the patient. It has been estimated that there is a minimum incidental cost of about £200 per year to the patient on long-term dialysis which could never be recovered from official sources. In one series eight out of nineteen men remained unemployed because of the difficulty in finding suitable work.

On the present estimates of an annual death rate from renal failure in the 15 to 54 age-group of 2,250 people, and taking into consideration the mean life expectancy of those on long-term dialysis, a sum of about £30m. per year would be required.

Of course, the money needed for research into kidney transplantation is not included. The success of this will, of course, remove a large proportion of the cost for dialysis.

Another example is the problem of survival after severe head injury. Four hundred patients with these injuries, by definition unconscious for at least one month after the injury, are admitted to hospitals in England and Wales every year.

The cost of care for this group of patients is considerable, but the final prognosis is surprisingly good. Improvement in cerebral function can continue for more than two years, and great care must be exercised when attempting to prognosticate in the early stages. The application of bio-mechanics to medicine has resulted in an increasing number of quadraplegics leading interesting and useful lives.

There is the problem of the aged and infirm who are in need of

minimal medical but nevertheless practically constant nursing care and attention. An article and Passim in the last issue touched on the difficulties which beset the persons involved in this problem. But the problem makes demands on the limited finances and argues that it makes them in the name of many more needy people than the examples mentioned above.

If highly complex methods of treatment were to be made available, then it is up to the profession to persuade the public to give medicine the economic priority which doctors think it deserves.

Within the profession there are numerous groups who press the Ministry of Health for more money from the budget. The Minister, in turn, competes with others for money from the National Budget, and Parliament decides how much money it is prepared to wring from the taxpayer's pocket.

The principle involved in all these decisions is that of priority. At present the country thinks that Defence, which costs each person £1 per week, should be very much higher on the list of Priorities than Health, Education, Social Welfare and many other "civilized" activities.

If this attitude continues to persist as it has for generations, then the poor standard of these useful and essential services will continue and the voter will get what he deserves.

Tower Block

To those of us who were becoming increasingly sceptical about the prospects of formal approval being given to the building of the new Tower Block and a definite date of commencement fixed on the actual building, the following information recently received will, we hope, to some degree restore faith in the administrative Frankenstein.

It is almost a year ago that Mr. A. E. Orchard-Lisle, the Chairman of the Tower Block Building Committee wrote to the *Gazette* saying that the Minister had agreed that the proper course was to go ahead with building the Tower Block, starting as soon as practicable. Since then the detailed plans of the various departments in the Tower have been prepared and approved by the Planning Committees and the final cost estimate submitted to the Ministry of Health. This has now been formally approved by the Ministry and the Governors have been authorised to proceed to contract for the Boilerhouse and for the framework, floors and external cladding of the rest of the building.

It is planned to invite tenders for the whole scheme in October this year and the Main Contractor should be appointed in the middle of December. This will enable a start to be made on the foundations in January next year.

Strawberries, Wimbledon, Henley and . . .

Continuing their protest against the foul machinations of man in the Park the birds the week-end before last sang out in fervent, almost Aldermastonian, voices under one of the brightest showers of sunshine we have experienced this summer (sic). The only remaining unadulterated lawn, thick and lush from compensatory overgrowth, called to the overworked, city-sullied souls of those of us who were on duty over the week-end. Succesfully. White coats were discarded, trips left waiting and even the colour supplements remained unread. We decided to entertain, specifically the patients in Nuffield House, and from the number of faces at the windows, we apparently succeeded. There was a new sound in Southwark. We played croquet.

We offer our congratulations to Dr. Ian MacDonald on his appointment as Professor of Applied Physiology at Guy's.

We would like to express on behalf of the many generations of residents who have benefited from the care and attention which Mrs. Baker, or as she was better known Miss Jean Bailey, has given to the comfort of their stay in residence. In the College and latterly also in the East Wing, she has given untiringly of her services for 21 years. We are sure she will enjoy the relaxation from a task which is unending in both its major and trivial details, no doubt enjoyable yet as frustrating and at times controversial as any which deals with the comfort of healthy people.

GUY'S DIARY

10th	M.	1.00	Clinical Lecture. Dr. BAKER. "The Heart as an Emotional Organ."
13th	Th.	1.00	Clinical Lecture. Dr. HARDWICK. "Sudden Collapse."
14th	F.	1.00	Clinical Lecture. Dr. ROSIN. "Diagnostic Difficulties in Old Age."
18th	Tu.	1.00	Clinical Lecture. Dr. ROSIN. "Old People with 'Nerves'."
20th	Th.	1.00	Clinical Lecture. Mr. LAWRIE. "Testicular Tumours."

BACTERAEMIC SHOCK

By

KEITH STEWART

Introduction

Bacteraemic Shock, caused by Gram negative bacteria, has been recognised with increasing frequency as a specific form of shock, since Waisbren[1] first described it in 1951. Bacteraemic Shock is caused by the release of endotoxins (lipopolysaccharides) into the blood stream—a response of Gram negative bacteria present in the blood. Hence the terms "Endotoxic" and "Gram negative" shock are synonymous with the term "Bacteraemic Shock". Apart from shock following myocardial infarction, bacteraemic shock is probably the most common specific form of shock. The condition is recognised chiefly by genito-urinary surgeons, though it is seen in other surgery and in medicine. It is an extremely dangerous condition, with a fatality rate of about 80 per cent. Treatment must begin as soon as the condition is recognised if the patient is to have a chance to live, and initial treatment must be supplemented with intensive nursing care.

Since the patient's prognosis may depend upon rapid diagnosis and treatment of the condition, a short summary of a large, comprehensive survey of Bacteraemia and Bacteraemic Shock, reported by Weil and Shubin[2], seems worthwhile. Their survey included nearly 400,000 "in-patients" at Los Angeles County Hospital, over a period of four years.

Incidence

In Weil's survey, there were 692 cases of bacteraemia reported, and 69 cases of bacteraemic shock. Shock was seen more in medical cases, and was more commonly seen in men than in women, though there was quite a high incidence in pregnant women and obstetric cases. There was also a high incidence in the "over 70 age group". Only 77 cases were attributed to surgery or urinary tract manipulation. Pelvic and perineal surgery, and urinary tract manipulation were the commonest causes of surgically related bacteraemic shock (82%), and wound manipulation and abdominal surgery were implicated in a total of 15% of cases.

One hundred and forty-nine cases were considered to have primary infections, with, in the majority of cases, a previous significant

history. Previous urinary tract infection was recorded in a quarter of these cases, and diabetes mellitus in one-fifth. Hepatic infection and septic abortion were also commonly implicated.

Symptoms

Bacteraemic shock is classically characterised by collapse with hypotension, high fever, respiratory distress (air hunger), and cold, clammy, pale and cyanosed extremities. These symptoms may not always present at the same time, but hypotension and pyrexia are the commonest. They may be accompanied by vomiting and/or diarrhoea (classically, a "greeny leak just prior to the onset of shock"), abdominal distension, and decreased bowel sounds. Gross malaena is occasionally reported. Hepatic abnormalities are common, and Weil and Shubin[2] found associated jaundice in some cases, but they attributed this to alcoholism. Hypothermia has been reported in a few patients, and flushed extremities in others.

TABLE

Table of Symptoms and their Prevalence, as reported by Weil and Shubin[2]

SYMPTOM	NUMBER OF PATIENTS PRESENTING WITH SYMPTOM [692 cases]
Hypotension	All cases
Pyrexia	153
	above 104°F. 40%
	above 101°F. 80%
Respiratory distress	53
Cold extremities	74
Vomiting and/or Diarrhoea	59
Malaena (gross)	15
Hepatic abnormalities	55
Jaundice (associated alcoholism)	31

Recent work[3] on animals shows that the shock due to endotoxin release (for such is bacteraemic shock) is due to an inadequate venous return caused by peripheral venous pooling. There is also thought to be a toxic effect on the myocardium. It is considered likely that similar factors are important in human cases of bacteraemic shock.

Shock lasted for an average of 2.3 days in the patients who went on to recover. In those who died of bacteraemic shock, the shocked state lasted for just over two days. Shock was found to occur, on average, 16 hours after operation or manipulative procedure.

Investigations: White Cells, Chemistry and Electrolytes

Weil and Shubin[2] noticed an initial leucopenia at the onset of shock which lasted briefly and then reverted to a massive leucocytosis within 24 hours. (Initially W.B.C. 10,800/cu. mm.; leucocytosis W.B.C. 20,000/cu. mm.) In the leucocytosis stage, the white cells are mainly polymorphs (84%).

The serum sodium and chloride levels were found to be lowered in about thirty cases, due to I.V. transfusion of non-electrolyte fluids.

Na^+ { 139.4 m.eq./L. initially,
133.8 m.eq./L. in shock.

Cl^- { 101 m.eq./L. initially,
97.1 m.eq./L. in shock.

Potassium concentration showed no significant change, despite oliguria in the hypotensive stage. However, serum bicarbonate levels reflected the general acidosis. Blood urea showed a markedly raised level in shock, which was thought to reflect the high incidence of renal infection.

Blood urea 54.6 mg.% initially
71.7 mg.% in shock.

Similarly, serum bilirubin was thought to be raised due to the incidence of hepatic disorders.

The blood culture is always found to be positive. Anderson[4] considers that the Gram negative organisms most commonly concerned in bacteraemic shock are:—Escherichia coli, Proteus, Pseudomonas species, and Paracolon bacilli. In Los Angeles[2], E. Coli was found to be the commonest, with Klebsiella aerobacter next most common, and Proteus next. However, Proteus was found to be the most fatal, followed by Klebsiella aerobacter, and E. coli was found to be least fatal of these three. They found one case each of salmonella and coliform; both were fatal. A few patients were found to have more than one type of bacterium on blood culture; in these cases the fatality was higher than cases infected by only one type of bacteria.

The bacteria cause the release of large quantities of lipopolysaccharides (endotoxins) into the blood stream, this being responsible for the collapse.

Treatment

Treatment must begin as soon as the condition is diagnosed. Immediate intravenous injection of the appropriate antibiotic is ideal, but when the causative agent is unknown the course of action is rather empirical. Ironically, the only course of action (I.V. antibiotics) causes the release of more endotoxins, due to the destruction of the bacteria. This, however, is better than not giving any treatment, as the antibiotics will reduce the level of bacteria by slowing the production of new generations. Prior to antibiotic therapy a blood culture should be taken, and a fresh sample of urine is occasionally a helpful guide to the causative organism.

Bacteraemia acquired whilst in hospital is likely to be resistant to a wide range of drugs, and the drug of choice is that which experience has shown to be most active against the particular hospital strain.

Often, a multiple treatment with more than one antibiotic is sensible. Weil and Shubin[2] found that, in their series, the best response was obtained with Streptomycin (2g/day) and Chloramphenicol (2g/day), with Tetracycline added to the therapy of those

patients who had not previously had this drug. However, in cases of urinary tract pathogens, Talbot[5] from Bristol found that Kanamycin sulphate (0.25% solution at 60-80 drops per minute) was a reasonable cover for up to 36 hours, until the results of the sensitivities are known. Talbot also advocated Chloramphenicol as an extra cover. Pseudomonas pyocyanea was found to be resistant to this treatment and Polymyxin B was used in such cases.

The need for keeping a powerful antibiotic, such as Kanamycin, in reserve for such emergencies cannot be stressed too much. The less a particular antibiotic is used the smaller the chance of resistant strains developing[6].

Venous return must be adequate, and this should be determined by monitoring central venous pressure. If venous return is low, it must be restored by transfusion. Weil and Shubin[2] thought that vasopressors might be of use to maintain blood pressure, and found that in conjunction with pharmacological doses of corticosteroids (more than 300 mg/day), vasopressors were of statistically significant value. Physiological doses of steroids are of little value, since the body does not lack corticosteroids in shock.

According to Anderson[4], some consider peripheral blood flow unimportant compared with the supply of vital organs, so that adrenergic blocking agents (phenoxbenzamine) should be given in the case of intense peripheral vasoconstriction, and this should be covered by the administration of whole blood or plasma to stabilize the circulation when the vascular bed expands. At the stage of vascular atony vasopressors may be given in conjunction with corticosteroids, which potentiate the effect of catechol amines on the smooth muscle in the blood vessel wall.

Weil and Shubin[2] found that prophylactic antibiotics for a few days prior to urinary tract manipulation lowers neither the incidence of bacteraemia nor the mortality rate from shock.

Summary

Bacteraemic shock is a common and fatal form of shock, characterised by sudden collapse with hypotension, caused by the release of large quantities of endotoxins into the blood stream. For treatment to be effective, diagnosis and the initial antibiotic therapy must be prompt. However, it is easier to prevent the condition than to cure it, and all precautions should be taken to ensure sterile conditions when operating or carrying out any manipulation of the urinary tract. Cases of bacteraemic shock always need intensive nursing care.

REFERENCES

(1) Waisbren, B. A. Arch. intern. Med., 1951, **88**, 467.
(2) Weil, M. H., Shubin, H., Biddle, M. Annals of Internal Medicine, 1964, **60**, 384.
(3) Weil, M. H., MacLean, L. D., Visschen, M. B., and Spink, W. W. J. Clin. Invest., 1956, **35**, 1191.
(4) Anderson, K. Clinical Practice of Bacteriology, 1966.
(5) Talbot, C. H. Lancet, 1962, **1**, 668.
(6) Leading Article, B.M.J., 1964, **1**, 254.

QUIZETTE : Neurology

1. Which of the following conditions are not associated with a paretic lange curve in the C.S.F.?
(a) General paralysis of the insane; (b) Carcinomatous cerebellar degeneration; (c) Subacute inclusion body encephalitis; (d) Multiple sclerosis; (e) Myxoedema.
2. Which of the following Neuropathies are commonly associated with hypertrophy of the peripheral nerves?
(a) Amyloid neuropathy; (b) Leprosy; (c) Peroneal muscular atrophy; (d) Thalidomide neouropathy; (e) Dejerine Sottas neuropathy.
3. Which of the following conditions may be associated with Myotonia?
(a) Duchenne dystrophy; (b) Refsum's disease; (c) Thomsen's disease; (d) Adynamia episodica hereditaria; (e) Wilson's disease.
4. Which of the following conditions may give rise to absent lower limb reflexes and extensor plantar responses?
(a) Subacute combined degeneration of the cord; (b) Motor neurone disease; (c) Friedreich's ataxia; (d) Tabo-paresis; (e) Spinal angioma.
5. In which of the following conditions may a Charcot joint be found?
(a) Leprosy; (b) Diabetes; (c) Porphyria; (d) Tabes dorsalis; (e) Syringomyelia.
6. Which of the following conditions may present with Dementia in middle age?
(a) Pellagra; (b) Myxoedema; (c) Parkinsonism; (d) Myaesthenia gravis; (e) Colloid cyst of the third ventricle.
7. Which of the following conditions may present with a unilateral ptosis?
(a) Myasthenia gravis; (b) Thyrotoxicosis; (c) Myxoedema; (d) Jakob-Creutzfeld syndrome; (e) Pick's disease.
8. The autonomic nerve supply to the parotid gland relays in which of the following ganglia?
(a) Otic; (b) Sphenopalatine; (c) Ciliary; (d) Geniculate; (e) Gasserian.
9. Which of the following conditions may be associated with papilloedema?
(a) Central retinal vein thrombosis; (b) Benign intracranial hypertension; (c) Respiratory failure; (d) Methyl alcohol poisoning; (e) Severe anaemia.
10. Which of the following conditions may be associated with a C.S.F. protein of over 200 mgms. per cent?
(a) Subacute combined degeneration of the cord; (b) Myxoedema; (c) Diphtheria; (d) Alcoholic neuropathy; (e) Motor neurone disease.
11. Which of the following conditions occur more frequently in the female sex?
(a) Myasthenia gravis; (b) Trigeminal neuralgia; (c) Motor neurone disease; (d) Carpal tunnel syndrome; (e) Huntington's chorea.
12. In which of the following conditions may impotence be a presenting symptom?
(a) Multiple sclerosis; (b) Wilson's disease; (c) Tuberose sclerosis; (d) Diabetes; (e) Peroneal muscular atrophy.
13. Which of the following do not cause intracranial calcification?
(a) Angioma; (b) Meningioma; (c) Craniopharyngioma; (d) Glioma; (e) Tuberculoma.
14. Which of the following substances may cause a peripheral neuropathy?
(a) Carbamazepine; (b) Nitrofurantoin; (c) Isoniazid; (d) Tri-ortho-cresyl-phosphate; (e) Thalidomide.
15. Which of the following conditions may be associated with abnormal pupils?
(a) Diabetes mellitus; (b) Refsum's disease; (c) Alzheimer's disease; (d) Myasthenia gravis; (e) Tabes dorsalis.

QUIZETTE ANSWERS

We would suggest, as the answers may for reasons of space be printed rather closely together, that readers answer all the questions before checking on the answers. We appreciate that the test is considerably more difficult this way.

1. **e**
2. **a b e**
3. **c d**
4. **a b c d e**
5. **a b d e**
6. **a b c e**
7. **a**
8. **a**
9. **a b c e**
10. **b c**
11. **a b d**
12. **a d**
13. **None**
14. **b c d e**
15. **a b e**

Compiled by R. G. LASCELLES and M. D. O'BRIEN

NOTICE

"Gilbert and Sullivan" at Guy's

It is proposed that, with the support of both the Music Club and the Theatre Club, performances of a Gilbert and Sullivan Opera (probably "The Pirates of Penzance") should be given in March, 1968.

A meeting will be held in the North Common Room at 5 o'clock on Monday, July 10th, in order that the enthusiasm of the members of the Hospital for this project can be assessed and preliminary auditions held.

Further details will be circulated as soon as possible or may be obtained from Nigel Winter, Musical Director, and Peter Davenport, Producer.

REVIEW

MEDICAL TERMINOLOGY FOR RADIOGRAPHERS, 2nd Edition.
by Paul M. Davies. Heinemann. pp. 274. *Price* 18s.

This book, written especially for radiographers, was first published in 1960 and has now been revised because of the widening scope and advances of diagnostic and therapeutic radiology. There are 150 medical terms which were not in the first edition, including those referring to new methods of treatment and also a useful glossary of prefixes and suffixes.

The Society of Radiographers has recommended this book to be included in its list of reading material for students as a knowledge of certain terms included in it is required of students for the M.S.R.(R.) and M.S.R.(T.) Diplomas. This knowledge is also of practical value as it makes radiography more interesting, helps the radiographer to understand the patient's condition and therefore choose the correct technique. Although primarily written for radiographers, this publication is not very specialised and could therefore be of interest to those engaged in other branches of the medical profession.

It is very good as a reference book but is in rather a condensed form for general reading purposes, although at the end of each section further reading matter is listed.

This book, in the form of a paperback at a very reasonable price, is easily carried on the person and can therefore be recommended for students and qualified radiographers.

JEAN SANGSTER ROBERTSON

THE MEDICAL PROTECTION SOCIETY

FOUNDED 1892

MEMBERSHIP EXCEEDS 45000

Membership secures protection of professional interests by a personal advisory service and the provision of unlimited indemnity against legal costs and damages.

Apply:—

THE MEDICAL PROTECTION SOCIETY
50 HALLAM STREET · LONDON · W.1
Telephone LANGHAM 9241

Senior Medical Secretary
Herbert Constable
MRCS, LRCP

Dental Secretary
Frank Allott,
LDS

AMERICAN ELECTIVE—or

I was the only one not chewing gum

by

Andrei Calin

I flew to New York in a V.C.10 and overtook some Boeings on the way. Unhappily, a few hours later I lay upside down with some Texans in a Greyhound bus between Cincinatti and Indianapolis. It had been snowing hard and we had overtaken the snow-ploughs that were clearing the interstate highway between Buffalo and Chicago. We must have hit a pile of snow, because over we went. I was the only one not chewing gum! From everywhere appeared police cars and ambulances, more snow-ploughs, and even a crane! Three hours later we started again. Our next stop—for hamburgers—was in Columbus, Ohio. We were now south of the Great Lakes and the temperature was still falling—and so was my morale. 5° below zero fahrenheit, and I was tired of Coca-cola! Everybody asked me: "Why are you going to the South-West? Why don't you stay in the great cities on the Eastern seaboard?"

I did not have an answer; except, I suppose, that I always like to be a little different. Then we turned south and passed through little towns and large fields; 500 miles later the snow turned to sleet, and 500 miles after that the sleet changed to warmth—the Mississippi and the America that I knew I wanted. No more snacks from now on; only T-bone steaks and California wines. The temperature was 74° F., and the New Orleans Jazzmen had taken a steamer up the Mississippi, bringing tropical fruit and music. I listened for a little and then my conscience beckoned me on to the medical centre of Missouri at Columbia.

I was impressed. The University of Missouri Medical Centre is a great new hospital built over the last nine years. It is a state-run regional hospital for wealthy white patients coming from the cities, St. Louis, Kansas, Jefferson (the capital), and for poor uneducated negroes from the Southern cotton fields and the tiny villages deep in the Ozark mountains. I was the first English student to reach this centre and everybody went out of their way to teach me, entertain me, help me, and make me feel much more important than I should have felt. Their only personal experience with Guy's Hospital was Lord Brock, who had spent one year at Barnes Hospital (St. Louis), and more recently had linked directly by telephone to Columbia from London in a cardiac conference.

It is said (by the pompous physicians of the Eastern seaboard and California) that in Missouri and Tennessee the Bible grips the country,

starving it of vitality. They say that the doctors go round with a stethoscope in one hand and a Bible in the other. How untrue! Unlike the deeply ill-bred hospitals of the East Coast, West Coast and some parts of London, this hospital is staffed by English, Canadian, Australian and American doctors—the latter coming from all the great cities. As frequently as one hears the suave nasal accent of doctors from Cook County, Chicago, or the slightly more rounded accent of those from Ohio State, Cleveland, so does one hear the unsophisticated drawl of the Texan from Houston or Dallas and the more swanky accent of the Gulf man from Tulane, New Orleans. There were even two negroes on the house, and a shame there were not more.

With ideas from all over the world and money from the State and federal banks, progress is inevitable. Of course, they have a vast computerized network system linking the hospitals all over Missouri; of course, they have private planes flying in radioactive mercury for brain-scanning and flying out their various professors to meetings and congresses in Washington, Seattle or Boston. And of course, the negro has to hitch-hike 300 miles to reach the hospital, terrified of spending his last days in renal failure, in debt to the hospital. In fact, the hospital is free for all those who cannot pay, but the negro especially has too much pride and will never come and beg for free medication unless he is more than half-dead and carried in by the family. But I was a guest in Missouri and it was their problem, not mine. I had, I hope, the maturity to keep out of their politics, and so I tried not to accuse them but to feel sorry, to keep quiet and to study good medicine. It was good.

I spent the month in neurology and enjoyed the excellent teaching and material available. I was particularly impressed and surprised by the individual approach that each patient received; no patient felt that he was just an object of interest in a vast intellectual mechanised atmosphere. The physician-patient relationship was certainly as good as the best at Guy's. Although this was true here, and again to a somewhat lesser extent at Boston, I understand that the reverse is true in many places, getting worse and worse until the Mayo clinic is reached, in Minnesota. There, on arrival from the local motel, the patient is split into eight equal parts; one part, the haemopoetic system, goes one way, the genitourinary system goes another, etc., etc., the separate parts joining at the end and paying the $300 before returning to the motel.

By now we are used to meeting Americans at Guy's and hearing that they begin their day at 7.0 a.m.; well, it is true! The day is so well organised; we never wasted time waiting for the professor or junior registrar. Everything is orientated towards the patient and the necessary investigations. During the early morning round the firm sees the patient and decides on the investigations required; these are carried out the same day and, at 5 o'clock, the evening round begins and the patient revisited. All the laboratory data is back! How refreshing when we compare it with Guy's—or maybe it is only my imagination that patients are dotted around our wards waiting for investigations or consultations and a diagnosis.

From the East of Missouri I moved west to Kansas City and worked for one week in an acute alcoholic ward. This entire ward (and in the same city, another entire hospital) was given to patients in alcoholic comas, Delirium tremens, Wernicke's encephalopathy, and Korsakoff's psychoses. This is a vast unsolved problem in the United States. I was interested to note that the patients came in after Bourbon or Vat 69—only the English alcoholic is so poor that he is driven to surgical spirit or other substitutes! The Dean of Kansas General Hospital warned me to return at night only by cab because to walk alone through the negro ghetto is dangerous. My second night I thought I knew better, so I walked. The experience was terrifying. Because I was white I was hated and abused. Since January 1st nine negroes have killed each other in that ghetto. How complacent we English can be if all we have to worry about are rising prices, George Brown and Ian Smith!

Missouri is not only famous for the river; it is the centre of fungal disease, chiropractice, osteopathy (the home of the late Dr. Stephen Ward) and, of course, the historical "Iron Curtain" speech of Churchill at Foulton, Missouri. Recently, at a cost of three-quarters-of-a-million dollars, a church was taken there, brick by brick, from London, but they had some difficulty because some of the bricks sank in the Missouri and the others arrived out of phase, making building construction difficult.

One hot morning in March I left the mid-west and reluctantly retraced my steps across the United States, via the frozen cascade of Niagara to Boston—The Massachusetts General Hospital (M.G.H.). In a recent survey of the American Medical Association, M.G.H. is ranked as the Number One hospital in the U.S.; according to M.G.H. it is the Number One in the world, and according to Missouri: —"The three most over-rated things in life are, one, 'Temporal pallor as a diagnostic sign in disseminated sclerosis', two, 'sex' and thirdly, 'M.G.H.'" M.G.H. has 1,000 beds and 1,100 doctors. A few look after patients but the remaining ones spend their time in different research units making sure that more papers come from M.G.H. than all the rest of the States together! The atmosphere is unbelievable. Everything is research orientated. (Even the cafeteria machinery producing two bits of bun for a dime or 10 dimes for a dollar looks like computer equipment.)

I was studying in the department of Professor Raymond Adams (the author of some 400 pages in Harrison's medical textbook). During the first morning I attended his neuro-psychiatric case conference. To my astonishment, half-way through, I was called upon to give my opinion of a case of Alzheimer's degeneration showing some catatonic features. This is so typical of M.G.H. No one is allowed to be a passenger. Everybody must speak and voice his thoughts, if only to mention some suitable reference.

A new snobism for an M.G.H. student is to be seen during the latter part of the week with a well-read copy of the *B.M.J.* or *Lancet* —it is taken for granted that he will have read already the major

American journals! A far cry from us in England. If by chance we know a fact that does not appear in the "lecture notes" series, we blush a little and suggest that we stumbled across the item in the popular press. Unlike my surgical and medical colleagues I did not start work until 7.30 a.m. (6.45 elsewhere). Lunch breaks do not exist; instead one collects a plastic container with drink and food and attends a working seminar where one of the residents discusses his latest research or an interesting patient is presented to a visiting resident from another service.

I was horrified at the shortened clinical course; only 15 or 18 months. But during this period the student spends 36 hours on duty and 12 off. He obviously gains by the continuity and much closer follow-up of the patient. Although this would be impractical at Guy's with our lack of accommodation, we would not only learn more but also find it easier to retain our enthusiasm. The student is also responsible (with minimum guidance) for initiating treatment and assisting at most of the investigations. His familiarity with the niceties of the case is double ours, and, of course, the pace is double. Attending the medical ward rounds in the famous Ether Dome is like being in an international airport. Anyone of importance, on the East coast for a few hours, would be expected to speak.

I was anxious while in the States to learn as much as possible about the latest techniques in research into Hodgkin's Disease. I was greatly assisted in this by Professor Alan C. Aisenberg of the immunology department; he has shown that one of the defects in Hodgkin's Disease lies in the lymphocyte which is qualitatively inferior to the normal lymphocyte. He has been studying lymphocyte transfer reactions and carries out quantitative estimations of the reactivity of normal and Hodgkin's Disease lymphocytes with $Thymidine_2$ ^{14}C. Although convinced that the cause is viral he remains despondent, "It being impossible to immunize the whole human race against a virus". Stimulated by T. B. Brewer's article (*B.M.J.* 20 August, 1966; Alcohol Intolerance in Neoplastic Disease), I was interested to find out whether any American workers in the field had found an equally impressive correlation between alcohol ingestion and induced pain localized in the Hodgkin's tissue. I drew a complete blank, the link considered to be little more than a chance finding. Then I spent some time in the Peter Bent Brigham hospital in the kidney transplantation unit. The hospital is the bank for the world literature of the recorded 1,137 cases of transplantation from 63 centres in 19 countries. A review is now being published. I was amazed while at the Belleview division of Cornell medical centre to hear over the intercom, that any doctor able to interpret Manchurian Chinese should go to the casualty department. Apparently this is a common occurrence, the Chinese almost outnumbering the Puerto Ricans in Down-town New York.

The American student at Guy's complains that our system is not sufficiently competitive. Although this criticism sounds acceptable I now know what competition means—name dropping about papers

read and exaggerated differential diagnoses ending in useless suggestions of cases, perhaps only twice described, and then in Bantu women! The good points are numerous—the students are much more involved with patient care, the post-graduate teaching is superb and everyone is conscious of the fact that one retires studying (and this is much more than a modest aside from consultant to student). We have so much to learn from their enthusiasm. I admired the way in which the professors and students are fellow-travellers, both intellectually and socially. Unhappily we only find this very favourable arrangement at Oxbridge. The reason for its absence in London remains incomprehensible. At least it cannot be a question of age! The vast majority of American doctors I met tried to persuade me to emigrate to the U.S. At the beginning it was easy to say No! I could think of hundreds of reasons against it, but by the end of two months I could think of only one or two little reasons, and so I quickly left.

Boston is a strangely historical and cultural city. It boasts of four great hospital centres, more Monet paintings than Paris, little English tea shops and one patient with continuation notes written by Sigmund Freud in Vienna 36 years ago. (She is, incidentally, still schizophrenic.)

This time I tried a Pan American Boeing. Everyone watched a movie, we were overtaken by one V.C.10, and I was the only one not chewing gum!

---

90 Years Ago

From Passim. July, 1877

Owing to our method of clinical work at Guy's, our nurses occupy a somewhat anomalous position; until very recently indeed, it was the commonest thing for the dressers on entering the ward in the morning to see the nurse on her knees scrubbing the floors, and it seemed unreasonable to call her away from the soapsuds to assist in dressing some case; now, we are glad to say, there are to be regular paid scrubbers.

From Passim. July, 1877

We believe the system of nursing in this Hospital is now undergoing revision, and that a new system will shortly be started.

50 Years Ago

From Passim. July 14th, 1917

It seems that some members of medical and surgical firms were in doubt as to what they ought to do in case of an air raid. We imagine that it is intended that they should go to their wards, especially the female wards.

From Passim 14 July, 1917

At a General Court of Governors held on Friday, July 6th, Mr. J. E. Humphery was elected a Governor of the Corporation. Mr. Humphery is connected with Hays' Wharf.

MUSIC

The Proms 1967

Later this month, London's professional music-making transfers for the rest of the summer from the newer and acoustically pure South Bank homes to the large, round monstrosity in S.W.9. The "proms" are here again. For the uninitiated this means 51 concerts in seven weeks. For all its sins, the Albert Hall provides at least one novelty—thanks to the famous echo, one can hear most of the sound twice!

Mr. William Glock, director of B.B.C. music, has produced fewer novelties this year, but the overall standard could well be much higher than usual. One new opera is Benjamin Britten's "Burning Fiery Furnace" (produced in Southwark Cathedral in the 1966 London Festival). This is performed with Schubert's heavenly Octet as a contrast. Mahler is represented by his 2nd, 6th Symphonies and "Das lied Von der Erde". Bruckner by the 9th Symphony. A major highlight is the appearance of two foreign orchestras—the Amsterdam Concertgebouw (one of the top six in the world) and the Polish State Radio Orchestra.

The standard favourites are there. Sargent (ad nauseum) in "The Planets", "Balshazzar", Elgar, etc. Sibelius is notorious by his absence from the programme. Hans-Schmidt-Isserstedt and Claudio Abbado make their conducting prom debuts. Benzamin Britten conducts Bach's St. John Passion. Perhaps this will be soloist year—for me, the highspot is Clifford Curzon, 60 this year, in Mozart (K491) and Brahms. Arrau and Barenboim play Bartok and Chopin.

As this year is the tercentenary of the birth of Monteverdi, two proms are devoted to his music.

The proms are fast becoming a great international music festival—they still represent incredible value to the student body. If one is selective one can hear the highest possible standard for 5s. The full prospectus is available from the Royal Albert Hall.

Record Review

Boulez Conducts Debussy **C.B.S. S.B.R.G. 72533**

("La mer", "Jeux", "Prelude à l'apres midi d'une faune")

To judge by the number of concert performances Pierre Boulez gives of these scores, they are clearly close to his heart. So much detail is revealed in these performances: for once, even "Jeux" makes musical sense (I've thought it previously a hotch-potch). "La Mer" is brilliant and exciting, "Prelude" is gentle and sensuous. The New Philharmonia are on top form (especially the woodwind section) and the C.B.S. recording is admirable—in fact, one of the best I've ever heard. I cannot recommend this record too highly to both the already converted or the unconverted.

Hedley Berry

CORRESPONDENCE

Mrs. Baker

SIR,—Mrs. Baker, better known to residents as Miss Bailey, has retired from the post of Matron of the College after 21 years in office.

All residents, past or present, who would like to show their appreciation of her many kindnesses, should send their contributions to the Honorary Treasurer of the Residents.

Yours, etc.,

JOHN COLLINS,

President of the Residents.

Guy's Royal Ascot Lunch Club

SIR,—On Tuesday, 19th, June, the annual meeting of the Guy's Royal Ascot Lunch Club was held in the Royal Enclosure. Present were Mr. and Mrs. Guy Blackburn, Dr. and Mrs. Scott and Mr. and Mrs. Patrick Clarkson.

Yours, etc.,

PATRICK CLARKSON.

107, Harley Street,
London, W.1.

White Coats

SIR,—I agree with Messrs. Scholefield, Briggs and Brangwyn John that all students should wear white coats.

The large pockets of the coats will enable one to carry a spare supply of ictotest reagent pads, which always seem to be missing, a pocket notebook, bleep when on take-in, stethoscope and other essentials without looking too much like a Michelin man.

At most other hospitals where white coats are worn, they are laundered regularly by the hospital; surely Guy's could do this, too.

Yours, etc.,

P. M. HUDSON.

East Wing,
Guy's Hospital.

Ambulance Education

SIR,—Some of your readers may know that during the last few months facilities have been provided for students from King's College and other London Hospitals to accompany the London Ambulance Service on " Emergency " calls, but that these facilities do not yet exist for Guy's students. The arrangement is that a student can accompany an accident crew for any period of the day or night, for any length of time, and on any type of call. He becomes effectively a passive member of the crew, and is encouraged to be more an observer than an active member of the crew.

He is thus afforded a very valuable opportunity of seeing illness where it occurs, and not only on a Casualty Trolley or in a hospital bed, and he sees for himself why the hemiplegic cannot be treated at home, and that the reason for the 30-year-old man's severe lobar pneumonia is that, due to the low I.Q. of patient and family, they have not sought medical advice sooner. These are things that one tends to meet rather suddenly when one becomes a houseman, and has the opportunity of talking to relatives at the time of admission, and cannot possibly be fully appreciated by any amount of questioning about the drinking habits of the patient's aunt. As a houseman, you can work out roughly what the home situation must be, by seeing the patient fresh from home, before he has been undressed and made into just another " body in a bed ", so how great would be the value as a student of seeing the patient in all the grime, filth, disorganisation, and poor facilities of his home. A certain amount of this sort of experience can be gleaned during a period with a general practitioner, but those periods are usually spent in places where rather better conditions prevail, and the grizzly truths of Chaucer House and the Tooley "Hotel" do not rear their ugly heads so strongly.

Other advantages of travelling with the ambulance are that the reception of an ill patient into various casualty departments can be seen, and the efficiency, layout, and general facilities of departments other than our own can be studied, and compared favourably or unfavourably with our department.

The Ambulance Men who have taken King's students around say that they have enjoyed the company of the students, and have found them helpful and co-operative, and interested in their work. Obviously the students must not be encouraged to play too active a part, as they are not qualified to give any form of treatment. If something were to go wrong they have no Defence Union protection, and they should obviously be warned about this before embarking on the project. However, there are times when they will be of great value, for example, as an extra man to restrain a strong, fighting patient, or in a case

where the crew are attempting resuscitation. In the latter case he will be of far more value than the man in the street who was told in a recent *Observer* Magazine to " press with all your weight just below the heart area " (no attempt to describe where the heart is, and no warning about the proximity of abdominal viscera), and then, on the arrival of the ambulance to " take the breathing bellows from the ambulance man ", leaving him to do heart massage, whilst the man in the street succeeds in sending a cooling draught over the patient's face!

I know that the proposal has been put forward that Guy's students should have this facility arranged for them, so that they may spend a free period by day or night with the Ambulance Crews, and I believe that the proposal has been turned down at consultant level. I wonder why?

I feel that the advantages greatly outweigh the disadvantages, and I wonder if it would be possible to sound out King's College and the Ambulance Service regarding their views and observations on the system before burying the proposal with all the other rubble in the park.

Yours, etc.,

J. S. GREGSON.

East Wing,
Guy's Hospital,
London, S.E.1.

Last Word?

SIR,—Mr. Richard Wakeland, though " rendered almost speechless ", managed to write a hard-hitting letter in the last issue of the *Gazette*.

I am surprised to see Mr. Wakeland suggest that there is " a very large number of people whose lives have been almost ruined by the ..... attitude of the Church ..... ". In what way? I would maintain that it is not the attitude of the Church, but promiscuity itself which causes ruined lives—the results of which are so clearly seen in unstable marriages and unwanted children. In fact, Christians have always been at the forefront of organisations which seek to help the unmarried mother (as they are in tackling the enormous problems of drug addiction and alcoholism). Mr. Wakeland's experiences of such organisations may well be atypical. The fact that the centres run by these organisations are almost always full suggests that the majority of unmarried mothers find them helpful.

Let us remember that this correspondence arose because it was suggested that a temporary relationship which resulted in a pregnancy could be described as responsible. Dr. Grimble has emphasised that "the family group is irreplaceable as a milieu for the healthy development of the child and its maturing responsible attitudes ". The B.M.A. report: " Venereal Diseases and Young People " quotes authoritative psychiatric opinion as saying that the disadvantages of promiscuity greatly outweigh any possible advantages. It goes on: " However, we have the greatest sympathy and understanding for young people who, following their natural inclinations, form attachments which although they may lead to engagement and marriage, may also lead them into a situation beyond their control..... We believe that young people should be made aware of the force of their emotions when physically aroused". (B.M.A., March, 1964).

I am sure that no doctor would refuse to treat a patient who had failed to take his prescribed treatment and had as a result become gravely ill. On the other hand, neither would he commend the patient for his foolishness. Similarly, as doctors (and as responsible members of society), we shall be failing in our duty if we do not firstly, point out to young people the many dangers of promiscuity, and secondly, be ready to help any who disregard our warning.

Yours, etc.,

MALCOLM J. H. HILLIER.

St. Christopher's House,
208, Long Lane,
S.E.1.

[*Eds.—This correspondence is now closed, but never the topic we are sure.*]

Facts are Facts and then some

SIR,—This letter from Messrs. Simpson and Orlans (May 13) came just as I was leaving for a holiday, and as I have done some research on the topics raised, this reply is somewhat delayed.

First of all may I say that normally I would not insult myself by replying to such an abysmal level of writing as shown by your correspondents, but as I have been challenged for proof, they will learn that I never refuse a challenge.

I heeded Mr. Simpson's request and read his letter again, and still the kindest comment I can find is that it is literary garbage.

Fact one: The estimated saving on the proposal for overseas students is £2-5 million, hardly a negligible sum. But the Government is to have a fund for hardship cases amongst overseas students. At the moment they pay £70 a year out of the average £250 per annum tuition costs. The proposal is for another £50, which still means the British taxpayer subsidises to the extent of some £130 a year.

Fact Two: The British taxpayer so derided by Mr. Simpson forks out at the moment £100 millions a year for the British students, something they should be thankful for. The last available full figures 1964/65 showed that local Authorities gave over £45 millions in University awards, and Ratepayers contributed £36 millions to students. The Government gives an average maintenance grant of £1,000 for a three-year course, and taking cost of tuition and maintenance, the average is some £900 per annum.

I am sorry to have to bombard you all with these figures but you must know the facts.

Fact Three: Last October nearly 6,000 acceptable British students were unable to find a University place despite the fact that since 1964/65 available places have risen by nearly 30 per cent.—I wonder how many would-be foreign students were unable to get a place here?

I would also remind Mr. Simpson and all students that at Leeds in March, Mr. Crosland stated that there was a good case for increasing the fees of British students as well, thus another burden on ratepayers. With these facts before them, I repeat is it any wonder that the ordinary men and women in Britain today have very little time and patience for the rantings, and sub-normal behaviour of certain sections of our students?

If Mr. Simpson really seeks to be the Cassandra of the *Guy's Gazette*, he must do his homework, and not argue by trying a literary disection on opponent's letters—he might cut his fingers.

Might I add that my facts were gleaned from kind co-operation from a National Daily and the Education Press Office, so they are accurate.

I think I have substantiated my original feelings without recourse to childish attacks so freely indulged by my critics. It is also for this reason that I, for one, now feel the subject closed.

Yours, etc.,

L. B. LUX

Strathyre,
Warwick Road,
Hale, Cheshire.

[*Eds.*—This letter has been shortened.]

NURSING SECTION

Who is Responsible ?

Recently an article in the *Sunday Times* provoked a great deal of comment and criticism. The stories told were shocking—" Huge wards filled with irrational and incontinent patients looked after by about only two or three nurses. Patients bathed about once a month, trails of faecal matter from bed to lavatory and back ".

These descriptions served to cause correspondence to flood the Nursing columns and cause comments in one or two of the National dailies. Some people have said—" Why were these criticisms not made years earlier, and why has the Ministry not done anything about them?"

It may be that many facts like those disclosed are known by the Ministry, but are hushed up because not enough people are interested enough to care or to do anything about them.

It is inevitable in our democratic and "progressive" society that the pressure of living is so increased that it is becoming a race for the survival of the fittest. Anyone unable to keep up with living at this pace becomes fallen by the wayside and is then merely a blot on the general public conscience.

What can be done to make our citizens more responsible for their elderly? Must we create a new society similar to that of some of the African tribes who are responsible for their old people and who preserve their dignity to the very end. Or perhaps our old people should be encouraged to follow the example of the Eskimos—the custom there being that when the old feel that they are becoming useless, then they crawl off out into the frozen wastes.

Much is written from the psychological aspect about care of the elderly. Preservation of their independence and dignity are two factors very high on the lists. However, for those old people who become, due to senility or infirmity, unable to look after themselves, then we shall have either to make their relatives responsible for them or else the State must staff and provide a good geriatric/psychiatric service.

Unless one is in the know, it is difficult to estimate how many of the criticisms which were disclosed were completely true, but there is always an element of truth about any fact published, although these are often exaggerated out of all proportion.

Care of the elderly has become a very highly skilled occupation carried out by a very few people who really are concerned. As our society is becoming more long lived than ever, old age is a growing problem. As we recognise it then so we must be more prepared to do something about it. Public funds will have to be appropriated into this branch of the Welfare State. Incentives for nurses and co-helpers will become necessary. If rates of pay are considerably raised for those working in geriatric fields, then this will be one method which should prove satisfactory and not merely from a commercial point of view. The provision of more geriatric community homes and hospitals should be of prime importance and are also now becoming an urgent necessity. Much more research into the type of community home which will be of the greatest value is also important.

These are only a few factors which will be involved in the care of the old and senile. Publication of some unpleasant facts may do much to awake public conscience, but in all cases they must be strictly the truth to be of any help.

STAFF CHANGES AND APPOINTMENTS

NEW APPOINTMENTS

S/N C. L. Hodson, (Waikato Hospital, Hamilton, New Zealand) to Main Theatres.
S/N K. LaReau (Johns Hopkins Hospital, Baltimore) to Outpatients Department.

DEPARTURES

S/N M. Chapple, from Hurst Ward.
S/N S. M. Chapple, from Luke Ward.
S/N M. Crispin, from York Clinic.
S/N R. Gardner, from Casualty.
S/N K. M. Jarvis, from Cornelius Ward.
S/N M. King, from Cornelius Ward.
S/N J. Nevill, from Mary Ward.
S/N M. O'Neill, from Lydia Ward
S/N L. Pullen, from Cornelius Ward.
S/N J. E. Ward, from York Clinic.
C/N V. Yates, from Psychiatric OPD.

SPORT

CRICKET

The latent guidance and telepathic support from Andy Proctor in the depths of Surrey were not sufficient voodoo to bring victory to " his " side when the Past played the Present at H.O.P. A fine opening partnership of 114 by the Past (replying to the Present 174—5 declared) seemed an adequate deposit for victory, but a solid attack by the Present dismissed the remaining eight wickets in eighty minutes for the further addition of only 48 runs.

On encountering Queen's University (fresh with the memory of two previous consecutive wins over Guy's), Guy's batted against an excellent demonstration of bowling and fielding and were eventually dismissed for 145. However, with 40 minutes to play, Queen's were 80—5, but a Guy's victory was thwarted by a tail end revival by Queen's. Queen's needing 8 runs in the last over, with a wicket in hand, found 7 of them to produce level pegging!

The 2nd XI with victories over Royal Free 1st XI and Bart's 2nd XI, have reached the final of the United Hospitals' Junior Cricket Cup to be played this week.

ATHLETICS

Ian Morgan, competing at Sandhurst, gathered two first places—firstly in the 440 yards in 48.8 secs., and an hour later in the 440 yards hurdles in 53.4 secs. With a personal best performance in the 440 yards and an improvement of 0.5 secs., we may speculate that his concentration on the 440 yards may reward him more favourably with a British University Team place.

BOAT CLUB

The Boat Club has undoubtedly had its most successful post-war season. The outstanding results for the Head of the River Race in the Spring (when the 1st VIII improved upon 82 places to reach the highest position in 10 years, and the 2nd VIII gained the position of last year's 1st VIII), gave promise for a fruitful season.

In the Hospitals Bumping Race, Guy's came third, and the 2nd VIII, not to be forgotten, again won the World Medicine Shield in the Hospitals Boat Race.

Seven Summer Regattas this season have seen Guy's in 5 finals and rewarded with 3 trophies:—

Horseferry (Kew)—Novice VIII: reached the final.
Putners Town—Novice VIII: won.
Junior IV: won.
Greenwich—Junior IV: won the final, but disqualified.
Richmond—Junior VIII: won.

These performances merit praise and we may indeed wonder how Guy's would have fared had Exams. and lack of funds not prevented them from entering the Henley Royal Regatta.

BOAT CLUB A.G.M.

At the Boat Club A.G.M. on 7th June, the President, Mr. J. Mansie, and the Vice-Presidents, were re-elected. The new officers elected for 1967-68 were:—

Captain—A. J. Hodgkison.
Secretary—T. A. R. Pook.
Social Secretary—J. Swain.

United Hospitals Rowing Club—Season 1967-68.

Captain: R. D. Forest (Guy's).
Secretary: T. Kirk (Guy's).

DIARY

CRICKET.

July 8.—U.C.S. Old Boys, 2.30 p.m.. Home.
„ 9.—Mayfair, 11.30 a.m. Away.
„ 12.—Wallington, 11.30 a.m. Away.
„ 15.—Nomads, 11.30 a.m. Home.
„ 16.—Streatham, 2.0 p.m. Home.

ATHLETICS

About April each discussions take place about how to make the current year Sports Day bigger and better than previous years, in spite of increasing disinterest among Guy's students in Guy's functions. Heated debate occurs on whether or not to mount a large advertising campaign and to provide numerous attractions in the hope of having a large crowd, on to let the general organisations be ruled by economics. whichever course is adopted the returns are bound to be small: one course is certain to make a large loss, the other may break even or perhaps make a profit. There is no way of definitely predicting which method will attract the greater support—the most important factor in determining this is the weather.

This year the committee decided to let the organisation be ruled by economics. Advertising costs were reduced by having "home-made" posters; only side shows which were certain to make a profit were arranged. For the same reasons it was decided to hold a dance at Guy's in the evening instead of having the traditional one at H.O.P.

After a week of unusually fine weather it was a great disappointment to have a cool cloudy afternoon on Saturday. This at once lowered the attendance figures. We were very pleased to have such good support from the staff; it is a great shame that more students do not show as much interest. Once again entries for the Athletic events were very limited. People just do not realise that the results are not a forgone conclusion. This was amply illustrated in the Javelin: N. Dodd was at H.O.P. playing tennis when the Javelin finals were held, after a few practice throws he decided to enter for the final and was placed second after a very close competition. F. Nwator ran a very fast 100 yds. in 10.1 secs. assisted by a following wind; the 120 yds. hurdles provided several surprises—but none of these from the winner, P. Domaingue. He also won the high jump and long jump, these points combined with a second place in the triple jump gave him a one point lead from Price, Voss and Choat so that he retained the Victor Lodorum title Perhaps the greatest surprise of the afternoon came in the housemans hundred which was won by Miss Ann Evans who set up a new women's record for this event!

After the beer race several participants were so inebriated that three different results were declared, eventually a team which had not declared its own victory was awarded the prize.

We are most grateful to Mrs Houston for kindly presenting the prizes at the end of the afternoon. We would also like to express our thanks to Harold Kirby for fulfilling the office of Starter for the afternoon. It would be impossible to mention all the helpers by names but we would like to thank them for their efforts and also to thank the members of the sports day committee for all their hard work before the day especially Mr. Goodliffe for sparing us his lunch hours to be the chairman of that committee. Sports day would not have been possible at all if it were not for all the hard work of Mr. Chick and his staff in preparing the grounds at Honor Oak Park.

As always the key man who deserves all the honour for the success of the day is the sports day secretary who was Malcolm Bates this year. All who enjoyed sports day owe him their thanks.

100 yds.—1, F. Nwator; 2, D. Barford
220 yds.— 1, D. Barford; 2, J. Price.
440 yds.—1, I. Morgan; 2, J. Price.
880 yds.—1, D. Choat; 2, B. Smith.
1 mile—1, D. Choat; 2, J. Harrild.
2 mile—1, D. Choat; 2, J. Harrild.
120 yds. Hurdles—1, P. Domaingue, 2, M. Bates.
L.J.—1, P. Domaingue; 2, M. Bates.
T.J.—1, M. Bates; 2, P. Domaingue.
H.J.—1, P. Domaingue; 2, R. Bailey.
W.—1, A Ross.
D.—1, G. Voss; 2, J. Stoneham.
J.—1, G. Voss; 2, N. Dodd.
H.—1, J. Wheeler; 2, Wiggins.
Clubs relay: Old Epsomians.

Several people had to leave before the prize-giving. Will anyone who won a prize and has not received it yet please contact D. Choat.

CRICKET

PAST v. PRESENT

At H.O.P. Saturday, June 24th

Result: Won by 12 Runs.

During the morning session, the Present scored 75 for the loss of 2 wickets. A new streamlined Gillham, slimmed by two months of hospitalisation, nevertheless failed to beat a fine return from Henriques, while Clark was well caught at mid-off off a mistimed drive. Butchey showing at last his 1966 form, and Silk survived safely until lunch.

Afterwards, the Past very courageously continued to field in what was at times very heavy rain. This made the ball almost impossible to hold, and Silk, Chase and Swift took full advantage of the bowlers' handicap. Trist was the most successful bowler; surprisingly, Davoobhoy had one of his rare blank days. The Present batsmen had obviously learnt how to deal with him while watching him wreck many an oppositions winnings.

The declaration left the Past 175 to make in even time. However, the time factor began to look quite inconsequential as Macgregor flayed the bowling. He played a brilliantly aggressive innings, and so dominated the opening stand that after an hour's batting he had made 75 out of the total of 100.

Even when both openers were dismissed with the score at 114, out to good catches by Butchey, a Past win seemed almost a formality. However, Clark and Beacham, bowling off a short run, had other ideas. Helped by a pitch that was dying out, they bowled accurately and to such good effect that the remaining 8 wickets fell in 80 minutes for 48 runs. This disastrous collapse, with the last wicket falling with ten minutes left, allowed the Present to gain a narrow victory by 12 runs.

Scores:

Present: 174-5 dec (Silk 57, Butchery 42, Chase 38).

Past: 162 all out (Macgregor 85, Clark 4, for 40; Beacham 4 for 46).

Past Team: H. Macgregor, R. Myall, J. Norman J. Powell-Jackson, J. Williams, A. Gunn, R. Trist, J. Munro, R. Henriques, S. Davoobhoy, W. Davies.

M. I. APPLEBY

GUY'S v. QUEEN'S UNIVERSITY, BELFAST
At H.O.P. Wednesday, June 28th
Result: Drawn.

A high proportion of the games this year have resulted in close, finishes, but none have been more exciting than this match against Queen's who were playing the first fixture of their week-long rows.

Remembering their two consecutive victories over Guy's, Queen's elected to field. Gillham was soon caught at slip, and the rest of the innings was a hard struggle for runs against tight, accurate bowling, supported by the fielding and catching. Most of the wickets lost were due to rash strokes played by batsmen frustrated at being tied down to such an extent. Clark, Swift and Carruthers, were the main scorers but no one batsmen really got on top of the Queen's attack. Martin an intelligent left-arm spinner, returned the fine analysis of 5-32 in 20 overs.

Queen's had to score at only a run-a-minute to win; but from the start they in their turn were subdued by accurate bowling, especially by Crafts and Davoodbhoy. Though on the whole the Guy's fielding did not match up to that of Queen's, mention must be made of good catches held by Davoodbhoy, and Chase.

With 40 minutes left, the scoreboard read 80 for 8, and a Guy's victory appeared probable. However, their late batsmen gradually changed the face of the game, with the result that at the start of the final over, 8 runs were needed with the last pair together. One run came off the second ball a pair was scored off the fifth ball, so that three runs were required off the last ball. Two runs resulted so that the match was drawn with the scores level. Davoobhoy took the bowling honours with his customary five wickets.

In the evening, Queen's lived up to their high reputation for sociability, providing a fitting climax to a really good game of criket.

Scores:
Guy's: 145 all out (Swift 30, Clark 29, Martin 5-32.)
Queen's: 145 for 9. (Davoodbhoy 5-53, Crafts 2-51.)

M. I. APPLEBY

BOAT CLUB

GREENWICH REGATTA

The Guy's coxed four competed in the Greenwich Regatta on Sunday, 18th June and although they did not win, they treated the spectators to a display of gentlemanly conduct that was a joy to behold. In their heat they easily beat Erith and so qualified for the final, during which the unfortunate events to be related, occurred. The final was between four crews: Poplar and Blackwall, Gladstone Warwick, Imperial College and Guy's. The crews were reasonably well matched and everything went well until a short distance from the finish. Poplar and Blackwall were leading, Guy's just second, Gladstone Warwick half a length behind third and Imperial College fourth when Gladstone Warwick (who were adjudged to be at fault) collided with Guy's and forced them to stop. Guy's requested a re-row but Poplar and Blackwall who had been beaten by Guy's the previous day at the Putney Town Regatta, hotly disputed this. Guy's request was upheld by the umpire who ruled that only Guy's and Poplar and Blackwall should compete in the re-row. The re-row took place over only half the course and during it Poplar and Blackwall were warned three times and Guy's once for taking the other crew's water (a crew is usually disqualified at the second warning). Just after the third warning and a hundred yards short of the finishing line Poplar and Blackwall took Guy's water, blades clashed and Poplar and Blackwall were able to streak over the finishing line whereas Guy's lost their rhythm and were forced to stop. Guy's protests were overruled by the umpire and the race was awarded to Poplar and Blackwall. Despite these trials and tribulations the Guy's crew returned to the boat house elated by the joys of competing and in no way disheartened by the vagaries of Fate. Congratulations, Gentlemen, on your behaviour: Pierre de Coubertin would have been proud of you.

Crew
Bow, A. J. G. Batch; 2, N. D. S. Bax; 3, J. A. R. Pook; Stroke, J. C. Millar; Cox, T. Kirk.

COLIN HUNTER-CRAIG

PUTNEY TOWN REGATTA

Junior IV
This crew was formed from the 1st VIII which disbanded after Brent regatta. In the first round they beat Vesta B.C. and Twickenham R.C. by ½ length. Next they beat Thames Tradesmen by 4 lengths. Before the final a worried Poplar, Blackwall and District crew made various complaints but Guy's settled their problems by beating them by 3 lengths to win the event.

Crew
Bow, A. Batch; 2, N. Bax; 3, J. Pook; Stroke, J. Miller; Cox, T. Kirk.

Junior Sculls
The Guy's entry, P. Gooder, was narrowly beaten by the eventual winner.

Novice VIII
Guy's had considerable confidence after getting to the final the previous week.

In the first race which was downstream was against Hertford College. After a somewhat erratic start Guy's took a two length lead after some hard rowing. They then eased off to win comfortably by 1¼ lengths.

The next race was in the opposite direction as the tide had just turned, and was against St. George's College. Guy's steered a straight course which although out of the stream, was shorter. This paid off and Guy's won by 2½ lengths.

In the final we met Staveley School, whom we had beaten at Horseferry. Guy's lost some distance on the start but soon pulled strongly past to win by 2 lengths after a very exciting race. Cox then received a traditional dip in the Thames and then the two victorious crews celebrated making use of the silverware which had been won.

Crew
Bow, P. Robinson; 2, R. Tudor-Williams; 3, A. Hodgkison; 4, J. Skuse (Capt.); 5, J. Swain; 6, A. Fenn; 7, N. Pinckney; Stroke, K. Sommi; Cox, R. Stanley.

RICHMOND REGATTA

Crew and boat changes were necessary after Putney Town but after three outings during the week the new crew was well co-ordinated and ready to enter a higher status Junior VIII's event. The course is a long, difficult one, round a slow bend, favouring the Middlesex station. However, Guy's had three races on the Surrey side and the cox made the best of this to the crew's advantage.

In the first round Guy's were surprised to have a comfortable row and easy win over Thames Tradesmen, beating them by 2¼ lengths.

Next they beat Tiffin School by 2 lengths. The semi-final, however, was more of a challenge. Harrow School, who were ahead on the start made a spirited effort to hold on to the overtaking Guy's crew but could not stop them winning by 1 length.

In their third final of the season the Guy's

crew met an experienced Midland Bank crew who have already won one trophy.

Prepared for their hardest row ever, Guy's soon settled down after a poor start to a steady row at 38 strokes /min. At halfway they were ½ length up but the Bank put up their rate and came back almost level. Guy's, however, also increased their rate to 40/min and pulled ahead to win by ½ length.

Midland Bank were quick to congratulate the Guy's crew, for this was an outstanding achievement for a crew which has not long been together and has had no coaching.

Crew

Bow, N. Pinckney; 2, R. Tudor-Williams; 3, P. Gooder; 4, J. Skuse (Capt.); 5, J. Swain; 6, A. Fenn; 7, J. Pook; Stroke, K. Somni; Cox, R. Stanley.

HOSPITAL INFORMATION

APPOINTMENTS VACANT

GUY'S HOSPITAL, S.E.1.

Applications are invited for the post of **locum Junior Medical Registrar** with duties to commence as soon as possible and appointment until 31st October, 1967. Forms of application are obtainable from the Superintendent and should be returned immediately.

GUY'S HOSPITAL, S.E.1.

Applications are invited for the post of **Junior Surgical Registrar** with appointment *from 1st October, 1967 for a period of two years* (renewable after one year). Applicants should have passed the Primary F.R.C.S. Forms of application are obtained from the Superintendent and should be returned by 21st July 1967.

GUY'S HOSPITAL
HOUSE APPOINTMENTS
September 1st, 1967

Applications are invited for the following house appointments due to begin on September 1st, 1967, applications giving choice of post in order of preference to be lodged with the Superintendent not later than **July 28th, 1967.**

House Surgeons 4
House Physicians 5
Gynaecological House Surgeon 1
Throat and Ear House Surgeon 1
Orthopaedic House Surgeon 1
Children's House Surgeon 1
House Physician to Dr. Bishop and Radiotherapy 1

The above appointments will be for six *months and will be open only to pre-registration* candidates applying for their first appointments and **not** to candidates seeking their second six months appointment.

Resident Obstetrician
(Post-registration) 1
Neurological House Physician
(Post-registration) 1
Dermatological House Physician
(Post-registration) 1
House Physician in Child Psychiatry
(Post-registration) 1
Casualty Officers
(S.H.O.) 4
House Surgeons to the Thoracic Unit
(S.H.O.) 1
House Physicians in the Department of Psychological Medicine
(S.H.O.) (From 1-10-67) 2
Resident Anaesthetists
(S.H.O.) 2
Children's House Physician at the Evelina Hospital
(Post-registration—to commence 1-10-67) 1
Casualty Officer at the Evelina Hospital
(S.H.O.) (Part-time 6 mornings a week) 1
House Physician to Dr. Mason and Dr. Cox at St. Olave's
(Pre-registration) 1
Gynaecological House Surgeon at St. Olave's
(S.H.O.) 1
House Physician in Medicine and Geriatrics at New Cross
(S.H.O.) 1
(Pre-registration) 1

P. J. Helliwell
Superintendent

June 30th, 1967.

[**Eds.** House Appointments in Guy's "sector" hospitals will be advertised in our next issue.]

PASS LISTS

ROYAL COLLEGE OF OBSTETRICIANS AND GYNAECOLOGISTS

P. M. F. Bishop has been admitted to fellowship ad eundem.

Fellowship

A. E. R. Buckle J. S. Tomkinson
J. M. Holmes

MEMBERSHIP

F. T. Brough H. D. W. Plowright
A. Parker

EXAMINING BOARD IN ENGLAND
FIRST EXAMINATION—L.R.C.P., M.R.C.S.

ANATOMY

B. F. Akasheh H. Nath
B. M. Crichton D. A. Rosenberg
S. F. Huggett C. H. Thorne
N. Longhurst C. B. Vulliamy
J. M. Morsman A. J. West

PHYSIOLOGY

N. Longhurst C. H. Thorne
J. M. Morsman M. N. Vellacott
H. Nath C. B. Vulliamy
D. A. Rosenberg A. J. West

CHANGES OF ADDRESS

Dr. P. D. Griffiths, 44 Seaforth Road, Broughty Ferry, Dundee (Tel. Dundee 76772).

Dr. and Mrs. M. Sneary, (Home) 55 St. Oswald's Road, London, S.W.16. (Surgery) 294, Brigstock Road, Thornton Heath, Surrey.

Mr. and Mrs. P. L. Snaith (née D. M. Potts) 234 Fambridge Road, Maldon, Essex.

PERSONAL

BEDFORD—Excellent opportunity to join young Guy's group practice in this busy county town. Expenses—shared partnership offered after short introductory period. Willis, Goddard and Burton, Bedford.

BIRTHS

McILLERON—To Geoff and Jill (née Joslin) B.D.S., on 19th June, 1967, at Marymount, Johannesburg, a daughter, Helen Margaret, a sister for Jane.

SNEARY—On 22nd June, at Guy's Hospital, to Patricia (née Robson) and Dr. Michael Sneary, a son, Martin, a brother for Linda and Andrew.

WEBB—On 26th May, at Sydney, Australia to Bob and Celia Webb, of Gladesville N.S.W. a son, Richard Adam, brother for Amanda, Bill, and Anne.

MARRIAGE

SNAITH-POTTS—On 10th June, 1967, at St. Wilfred's Church, Davenham, Cheshire, Philip Leonard Snaith to Diana Mary Potts, S.R.N.

DEATHS

SUNAWAY—On 17th June, suddenly, Victoria age 17 months, beloved youngest daughter of Jill and Keith, darling sister of Nicola, Andrew, and Sara. 58, Warrinton Road, Ipswich, Suffolk.

Attention is drawn to the fact that the "Gazette" is now available at a reduced subscription rate of £1 1s. 0d. p.a. for the first three years after qualification.

We would like to remind our readers that all copy for inclusion in the Gazette must be received eight days before the publication date.

Personal notices one shilling per word (Minimum £1. 1s. 0d.)
Birth, Marriage, Death and Change of Address notices are without charge to subscribers.
Non-subscribers will pay £1. 1s. 0d. for all notices other than Personal.

GUY'S HOSPITAL GAZETTE

EDITORS D. S. ROBINS and C. B. BROWN
SPORTS CORRESPONDENT J. G. PAYNE
NURSING CORRESPONDENT E. A. MALPAS

FORTNIGHTLY TWO SHILLINGS VOLUME 81 NUMBER 2061

The opinions expressed in these columns are solely those of their authors and are not to be taken as the views of the Hospital as a whole.

PASSIM

Professor Sir Hedley Atkins

The Guy's Community as a whole was delighted when Professor Atkins was awarded the K.B.E. in the recent Birthday Honours. They were well aware of the many services he had given towards both the cause of surgery in this hospital as head of the Department, and that of medical education. The latter was particularly evident to generations of Guy's students in the excellent and, what is rare nowadays, popular courses of lectures he gave on Surgical Pathology in the Gordon Museum.

Many, however, may not know quite as much about his other activities, particularly those in connection with the Royal College of Surgeons of England. Sir Hedley Atkins became a Member when he took the Conjoint qualification in 1932, was awarded the Hallett prize for the best marks in the Primary Fellowship examination in 1930, and was admitted a Fellow in 1934. He was a Hunterian Professor in 1938, lecturing on Chronic Mastitis.

He was appointed to the Court of Examiners in 1949, and elected to Council in 1952 (re-elected 1960). He has taken a very full share of committee work, notably on the Building Committee during the restoration of the College which was completed only in 1962, the Committee on Training of Surgeons, and on the Library Committee of which he was Chairman for five years. He represented the College on the General Medical Council from 1955, and was Dean of the Institute of Basic Medical Sciences (the College's graduate teaching departments) from 1957 to 1962. He was a Vice-President 1964-66, and was elected President in mid-summer 1966.

He is the College's tenant at Down House in Kent (Charles Darwin's old home), and Honorary Curator of the Darwin Museum there. He has been most generous in providing funds for its restoration. Sims Travelling Professor for the College in 1961, visiting Australasia, he also gave the Vicary (historical) Lecture in 1964 on "The Darwin Tradition", and the Bradshaw Lecture in 1965 on Cancer of the Breast.

Quite apart from this prodigious activity at his professional *alma mater*, he has remained very much a Guy's man. We are confident that his continued presence in the hospital will continue to inspire those who study and work here to earn in their own particular fields the distinction and respect which he has so deservedly earned in his.

Political Geriatrics

A "New Deal". Every other night and every other week-end off, and newly-instituted opportunities for paid study leave for the hospital junior doctors. These were the momentous words announced recently by the Ministry with philanthropic energy, efficiency and enthusiasm. The Ministry was pleased—they could show they were apparently doing something for the lot of the hospital junior doctor so as to help stem the "Brain Drain". The B.M.A. were pleased, for here was more to counteract the criticisms of their partners in virtue, the Hospital Junior Doctors' Association.

It is a matter of incidental mourning that little mention was made about extra staff in the form of locums to stand in when the recommended time-off and periods of study leave were being utilized. Almost naturally, no extra money was apportioned to the already over-stretched hospital budgets to pay for such locum staff or for the alternative increase in the number of junior jobs available within each hospital to spread the work. And of course it would be the easiest thing in the world for the hospitals, as they have been asked by the Ministry, to provide both the time off and the finances for additional staff and then to report back within a matter of months as to their success (—or failure?).

The situation at many hospitals regarding terms of service for "junior" medical and surgical staff will now, conveniently for the Ministry, become entirely dependent upon the individual Group Management Boards (this peculiar term "junior" still being taken to cover the whole of the really rather amorphous aggregation of those anywhere below Consultant status). It will be up to the Boards to decide what they will have to forego to provide these terms of service and indeed decide whether they will in fact forego anything. Of what National or standard purpose then is the Ministry ruling, one may rightly ask.

Were the noses of the B.M.A. not still twitching with the sweet smell of success, they might have looked in the Ministry's mouth. They would have instantly noticed the particularly dry and furred tongue of chronic legal tender failure. For it is with such a tongue that the Ministry have issued the instructions to hospitals in much the same way as they might have asked an impoverished, uncivilized Eskimo to play the Second Brandenburg Concerto on his own Stradivarius. The nature of the latter request would be to produce little if any sound, let alone music. The nature of the former, we fear, is once again monotonal hot air.

Under the Bureaucratic Volcano

We congratulate the building contractors on the efficiency with which they have consumed another large section of the Park, that in front of Shepherd's House. Their aesthetic taste in the construction, design and deployment of huts, both in the erected and dismantled state, is to be admired as a welcome change from the antiquated, boring vegetable creations of Mother Nature. Students and patients are learning to appreciate the exquisite sensation of relaxing during their lunch hour on a bed of nails, rubble, planks and intermittent grass leaves with the cool sound of the mechanical drills and endless hammers wafting into their ears. With the right support and breaks of luck, the contractors may be able to achieve an ideal staging of their work such that they need only occupy the Park in the pleasant, sunny summer months. All strength to the Progress Crusade. Long live Brother Kafka.

Old Books of the Wills Library

The study and appreciation of old medical books is one that, unfortunately, comes late and infrequently to many members of the medical profession. Their diagnostic vocabulary, sprinkled as it is with eponyms, would lead the dispassionate observer to expect a much greater interest than is at any rate readily evident. Passively through lack of stimulus or introduction, or actively this side of their professional education increasingly would appear to support Henry Ford's unfortunate dictum, "History is bunk".

Libraries achieve much of their distinction through the extent of their collection of historically important books and manuscripts. The value of such collections has dimensions which far exceed those financial. The Wills Library here at Guy's is no exception as the observant will no doubt have long ago appreciated. One effect of the reorganisation of the Library has been the liberation of the rare and classical antiquities in its possession to the closer attention of regular visitors, many of whom have been and no doubt will be at least mildly surprised at the wealth of material that has hitherto lurked on ignored shelves and in untouched cupboards.

In this issue we print the first of a series of articles written by Mr. William Hill, the Wills Librarian, around some of the antique literary works to be found in the Library. It is our hope that these short articles will interest the converted and help to stimulate a greater interest and respect for the writings of old amongst those whose sense of achievement revolves almost exclusively around their having read the latest abstruse article in the newest obscure journal. The articles may yet help to persuade the unconverted that it was Ford's dictum rather than history that was bunk.

We would like to thank collectively the many readers who responded so magnificently to our plea for certain missing numbers of the *Gazette* a short while ago.

We are sure many of our readers will be sad at the news of the departure of a feature of Guy's who has at various times received mention in the *Gazette*. On Sunday evening, 2nd July, 1967, Mr. Wheeler's dachshund, kennel name Otto von Aachen, better known to the family and friends as "Puffin," died in the Medical School. He was thirteen years of age.

GUY'S DIARY

We offer our congratulations to Dr. Joan Baker, who has been appointed Consultant Radiotherapist at the Royal Marsden Hospital.

We offer our congratulations to Mr. J. P. A. Weaver, who has been appointed Consultant Surgeon to the South Teeside Hospital Group.

JULY

24th	M.	1.00 Clinical Lecture. Prof. HENRY N. WAGNER. "The Current Status of Nuclear Medicine II."
25th	Tu	1.00 Clinical Lecture. Mr. HOSKINS. "The Post-Gastrectomy Syndrome."
27th	Th.	1.00 Clinical Lecture. Mr. LAWRIE. "Ulcerative Colitis."
28th	F.	1.00 Clinical Lecture. Dr. KAUNTZE. "Fluoroscopy of the Heart."

DR. W. M. BROWN

Dr. William Mark Brown died in Christchurch, New Zealand on June 6th, 1967. Having qualified from Guy's with conjoint in 1920 and M.B., B.S. (Lond.) 1921, Dr. Brown received his M.D. in London in 1930, and the same year became F.R.C.S.(Edin.) in 1930. Two years later he became F.R.A.C.S. In General Practice for some years in Christchurch, New Zealand, he then became Gynaecologist to Christchurch Hospital until his retirement in 1956, continuing in practice until 1962. His particular interest was the treatment of pelvic cancer. He was a former President of the Canterbury Division of the B.M.A. and served in both World Wars, being the first New Zealander to land in Sicily in the second. He is survived by his son, an architect, and two daughters.

ANAESTHETICS AT GUY'S

by

A. M. HUTTON

The Department of Anaesthetics was established at Guy's Hospital in 1947, operating from a small, cell-like room in the basement of Old Guy's House.

At that time the staff comprised four part-time consultants including the director, an assistant director, two residents and one research assistant, eight in all. The total anaesthetic staff of the Guy's group now numbers 23 and compared with other similar teaching hospitals this is a modest figure. The objects of the department were to improve the teaching of anaesthesia, to stimulate some much-needed research in this subject and to organise and develop an efficient anaesthetic service to the hospital.

An anaesthetic service can be offered in two ways. Either an anaesthetist is allotted to a surgeon on a daily basis according to the needs of the moment, or an endeavour is made to foster the principle of the "surgical team" where the same members of the team work together as much as possible. The latter method is adopted at Guy's because it is felt that it adds to efficiency in the operating theatres, but there is no doubt that this system is more difficult to administer.

It was announced that there would be considerable expansion of the surgical side of the hospital during the rebuilding and reconstruction of Guy's which followed the war and the advent of the National Health Service. The degree, however, of this expansion was greatly underestimated at that time.

Since 1947 the anaesthetic services have increased considerably to cover surgical demand at the Maudsley Hospital, the Evelina Hospital and more recently St. Olave's and New Cross Hospitals. In the earlier years, the increase was relatively slow, largely due to the arrival and development of the neurosurgical unit at the Maudsley,

and the birth of cardiac surgery as a speciality in its own right at Guy's.

Due to the opening of New Guy's House in April 1961 more ward space and operating theatres became available for surgery. The ENT and Orthopaedic departments returned from New Cross to the parent hospital and the Departments of Surgery and Thoracic Surgery increased in size. Henceforth, the tempo of change quickened, not only with regard to the total number of operations performed and the number of surgeons operating at any one time (owing to more theatres being available) but also in many instances, the types of operations performed became more complex and prolonged. This aspect of events is best illustrated by the open-heart operations and the prolonged investigations in the Radiology Department which precede the actual surgery.

There were two further important developments at this stage both of which affected the Department of Anaesthesia. Firstly, the creation of the Respiratory Function Unit; and secondly, the acceptance by the hospital of the conception of an intensive care ward.

In collaboration with the Department of Medicine, arrangements had been made for the establishment of a Respiratory Function Unit in New Guy's House during the planning stage of the building. Space was therefore immediately available on the second floor and the unit commenced functioning as soon as the new block opened.

INTENSIVE CARE

The situation with regard to the intensive care ward was different. When the plans were drawn for New Guy's House the idea of an intensive care ward as we know it today did not exist, and therefore no space had been set aside for such a unit. In 1959, however, Lord Brock had obtained a small room in Old Guy's House with its own special nursing staff, minimal equipment and facilities required to care for patients during the first few critical days following open-heart surgery. Owing to the success of this ward, space was found as a matter of urgency on the theatre floor of New Guy's House in order to continue intensive care treatment. This site proved unsatisfactory for many reasons and intensive care was moved to its present site on the third floor of New Guy's House and named Cornelius Ward in 1963.

It is worth noting that Guy's was one of the first hospitals in the country to implement the idea of an intensive care ward in order to improve the immediate post-operative care of severely handicapped patients following major surgical procedures.

To an anaesthetist, an intensive care unit is synonymous with a respiratory support unit and the patients within such a unit not only require the constant nursing attention which is necessary for any type of severely ill patient, but they also require—or may require—relatively prolonged automatic ventilation of the lungs by means of mechanical ventilators. In a mixed medical and surgical intensive

care ward such as Cornelius, there are two main types of patients requiring automatic ventilation. The first type has a weakness of the respiratory muscles although the lung function may be near normal. The second type, very much more common in Cornelius, which is mainly a surgical intensive care ward, has pathological changes in the lungs which inevitably reduces their efficiency, although the respiratory muscles themselves may be relatively intact.

In any event, some impairment of respiratory function can be demonstrated after major surgery due to increase in the physiological shunt from continued pulmonary perfusion of unventilated alveoli. This is particularly apparent following open heart surgery and now almost all such patients are ventilated for at least 24 hours, post operatively. Respiratory support of this nature can only be undertaken if measurement of the patient's blood gases and acid base balance is available at all times. This means a twenty-four hour service undertaken for Cornelius by the anaesthetic registrars in a small laboratory next to the Respiratory Function Unit.

RESEARCH

A very large part of the research effort of the Department of Anaesthetics since 1963 has been directed to improving the care of patients in Cornelius by the application of the known principles of respiratory physiology. The improvements in medical technology over the last decade have made this a practical possibility, but it is often extremely difficult to bridge the gap between modern theory and standard practice when dealing with patients who are critically ill. It is for this reason that the advances made in post-operative respiratory care are sometimes rather slow in development. For example, in 1959 there were relatively few mechanical ventilators on the market and those that were available had been designed for the most part for use in operating theatres. Only bitter experience has shown that a ventilator which is very satisfactory in performance in an operating theatre may be quite unsuitable for prolonged IPPR in a ward. Different types of ventilators possess different characteristics and there is no such thing as an all-purpose ventilator which can be used on all patients with maximum efficiency. In many respects mechanical ventilators are similar to motor cars—one buys the model most suited to one's specific purpose bearing in mind the amount of money that one has available. In the hands of bad or careless drivers, cars can easily become lethal instruments; so can ventilators. Without constant care and maintenance both types of machines will soon grind to a halt; this may no more than cause inconvenience to the driver of a car but it can be hazardous in the extreme for the patient who is being mechanically ventilated. We have always tried to purchase ventilators which are relatively simple to operate and require the minimum amount of maintenance both for financial reasons and also to make supervision easier for the nursing staff.

Due to the ever-present dangers of infection and cross-infection, ventilators and their humidifiers, tubing and connections must be thoroughly cleaned and in some cases sterilized between cases.

At Guy's, original work has been done both with regard to the sterilization of ventilators using Ethylene Oxide and by the introduction of bacterial filters into the ventilator circuit to prevent contamination from the patient and from and into the outside atmosphere. In many instances this obviates the necessity of the time-consuming ethylene oxide sterilization. It undoubtedly adds to the safety of the patients in the surroundings and circumstances in which we work. The overall success of this policy of respiratory support can best be judged by the ever-increasing number of patients receiving ventilator treatment in Cornelius over the last few years.

In 1963 forty-five patients received ventilator treatment. This figure had risen to 165 out of a total of 297 admitted into Cornelius in 1966, thereby showing that the indications for artificial respiration are broadening.

We have learned some lessons. A ward such as Cornelius can only function in a satisfactory manner as a result of team-work put in by a large number of different people each with their specialized skill. Physician, surgeon, cardiologist, anaesthetist, clinical pathologist, physiologist, radiographer, physiotherapist, *et al*, all play their parts; but, the final success or failure will depend on the efficiency and devotion to duty of the nursing staff, and in particular on the trained sisters in charge of the unit. Today there is a chronic shortage of nurses and general financial difficulty. Maintaining a patient in an intensive care ward is expensive both in the number of nurses required and in the actual cost to the hospital. The only justification for such a unit is the overall reduction in mortality of many different conditions which can be achieved in this type of ward.

EDUCATION

Apart from organising an anaesthetic service for the Guy's Group of Hospitals and the Intensive Care Ward, the main function of the department is to teach medical and dental students practical anaesthesia.

I believe that any doctor worthy of the name should be able to give a patient a simple, straightforward anaesthetic in an emergency, in circumstances when there is no expert anaesthetist available. These circumstances are unlikely to be found in this country today but there are still many parts of the world where professional anaesthetists hardly exist and students may find themselves working in such surroundings. This is one reason that most of the teaching is based on the apprentice system in the operating theatres or in the out-patient department.

Both medical and dental students receive some theoretical instruction in the form of set lectures. The difference between the theory and practice of anaesthesia is very appreciable in 1967 and it is preferable to demonstrate some simple principles of elementary physiology, pharmacology and resuscitation in the operating theatre, rather than to add to the already formidable list of official lectures which the

students are forced to attend. The Medical School supplies knowledge of the Basic Science, upon which all practical anaesthesia and the effects thereof must be built. A mass of new information has resulted in the wake of the immense amount of suitable and technological advances in these subjects over the last twenty years. There are many bricks with which to build. As far as anaesthesia is concerned the department attempts to supply some degree of filtration of new information, so that the individual anaesthetist may dispense with the inessential and concentrate on applying to clinical anaesthesia those relatively few bricks which are quite literally vital.

It is possible to monitor many different parameters in anaesthetized patients with regard to their cardio-vascular, respiratory and bio-chemical state. This facet makes life very interesting for all concerned in the operation and on occasion is undoubtedly beneficial to the patient. Monitoring of patients, however, can be undertaken unnecessarily, in which case it wastes time and is of no advantage to the patient; it may even act to his disadvantage and therefore should be kept to a minimum. This is just one example of what might be called "clinical common sense", a factor which is quite essential to any doctor whatever his speciality, but is particularly necessary in the case of an anaesthetist.

Therefore the second reason why we try to teach in the actual operating theatre or during a dental session in out-patients is that this type of common sense can only be demonstrated by example in the actual surgical arena.

This method of teaching adds in no small way to the overall difficulties of both surgeons and anaesthetists when they are working in main theatres or in out-patients. Inevitably the speed of the operating list is reduced, at a period of time when the actual duration of lists is causing concern. For many years Guy's surgeons and anaesthetists have accepted this difficulty as a part of life in the hospital. One hopes that this acceptance will continue for many future years in the interests of undergraduate training.

OBITER DICTA

Patient: To student examining the vagina of an obese West Indian lady, after two minutes of palpation: "Man, if you don't stop that mighty quick you's gonna ring ma bell."

Laundry on phone to Dorcas Ward: Please would you use more linen on the ward as our workers want more overtime.

WILLS LIBRARY ANTIQUITIES

I. JOSEPH WARNER

By William Hill

Joseph Warner, Surgeon to Guy's Hospital from 1745 to 1790, was born 250 years ago. His family had estates in Antigua where he was born in 1717. In later life he inherited the estates, together with the family's most treasured possession—the gold ring which was given by Queen Elizabeth to the Earl of Essex and which failed to be returned to her in time to prevent his execution. According to family tradition it was given to an ancestor by James I but there is another ring about which the same story is told.

Warner was sent to England to be educated and entered Westminster School. At the age of 17 he was apprenticed to Samuel Sharp, Surgeon to Guy's. In 1745 he volunteered to go with "Butcher" Cumberland's expedition to Scotland to put down the rebellion, and while on the campaign he heard of a vacancy on the staff of St. Thomas's but he was too late to reply. It is said that Cowell, the successful candidate, kept his colleagues in Cumberland's army in ignorance of the vacancy until it was too late for them to apply. Warner was always on bad terms with Cowell following this incident.

Warner had not long to wait before his chance came and in the same year was appointed to Guy's in succession to James Pierce. When Sharp gave up his lectures Warner took them over. At this time the outgoing lecturer was free to appoint his successor. Warner served on the staff of Guy's longer than any other man, 45 years in all. He retired in 1790 and lived another eleven years.

During his career he wrote three books, all of which are in the Wills Library. The first was *Cases in Surgery, with remarks . . .* published in 1754 with further editions in the same year, 1759 and 1784. The dedication is to the Treasurer and Governors of the hospital and includes the lines

> "an [sic] hospital is not only the instrument of relief to the distressed who are immediately received there, but also a means

of helping others, by furnishing such principles and practice, as may improve the art of surgery and thus render the benefit more general."

These words used to appear in the opening pages of *Guy's Hospital Reports.*

The cases discussed give a good indication of the state of surgery during the middle and latter half of the eighteenth century. Some have a familiar ring—

"A.B., aged 25, in August 1747, broke her knee-pan by a fall downstairs" and

"A.B. accidentally run [sic] his hand through a pane of glass, which cut his wrist on the fore-part, quite a-cross."

Others are not quite as familiar—

"In the year 1748, R.L., a boy of 14 years of age, had the misfortune to fall from the mast of a ship and to pitch upon the back part of his head a little above the conjunction of the parietal bones with the occipital bone",

and

"On the 9th October, 1749, J.L., aged 44, received two remarkable wounds from his antagonist, who struck him with a hedging-bill".

Some of the cases had appeared in the *Philosophical Transactions of the Royal Society,* he having been elected a Fellow in 1750. He is also alleged to have been the first surgeon to tie the carotid artery, an operation he performed in 1775.

His reputation rests on the *Cases in Surgery* but he wrote two other books, *A description of the human eye and its adjacent parts,* 1773 and a second edition in 1775, and *An account of the testicles, their common coverings and coats,* 1774 and a second edition in 1779. In 1792 there was considerable ill-feeling at St. George's Hospital because of the reluctance of John Hunter to pool his lecture fees with his colleagues. His rival, Mr. Gunning, wrote to the other London surgeons to find out the practice at other hospitals. Warner replied, and his letter gives a full account of the teaching at Guy's and St. Thomas's during the last half of the eighteenth century. This is reprinted in Cameron's *Mr. Guy's Hospital* and is well worth reading.

After his retirement, Warner lived in Hatton Garden, where he died in 1801. It is said that he, Sharp, Hawking and Bromfield shared the surgical practice of London between them and effectively prevented John Hunter from being recognised earlier.

The books mentioned in this account will be on show in the Wills Library for the next fortnight.

THE SCHOOL FOR DENTAL AUXILIARIES, NEW CROSS HOSPITAL

THE GREAT EXPERIMENT

by P. W. F. LAMBDON

Proposals for the extended use of ancillary dental workers were first discussed over 40 years ago, but it was not until the 1950's that proposals for an experiment in the training and employment of those now known as Dental Auxiliaries were made.

Just before the Second World War the building of a new Isolation block at New Cross Hospital was commenced. With the advent of war all hospital building projects were shelved and the wards were never completed. It was not then realised that this building would become the training centre for the auxiliaries.

The Dentists Act of 1956 made provision for trial of a new class of ancillary dental workers to undertake filling of teeth and extraction of deciduous teeth, and employed to do work of that kind in the course of the provision of national and local authority health services.

Fig. 1
THE "PHANTOM HEAD" ROOM
where students learn the essentials of Operative Dental Surgery.

The Act provided for an experiment to be set up by the Privy Council under the auspices of the General Dental Council. Its object was to assess the value to the community of such ancillary dental workers.

A building on available property was sought and the New Cross building was obtained. It consisted of sixty small wards on two floors; it was replanned and partially rebuilt to provide, on the first floor a training school for the 120 students it was to house, and on the second floor a clinic with thirty-one individual surgeries for the students.

In the completed building the first floor houses a "Phantom Head" room (Fig. 1), with provision for 60 students to learn the principles of operative surgery, together with changing rooms and in two wings, two large lecture rooms each designed to accommodate sixty students. The surgeries on the ground floor, although partitioned to provide some privacy, are separated by glass panels to enable the students to be seen easily by demonstrators and tutors (Fig. 2).

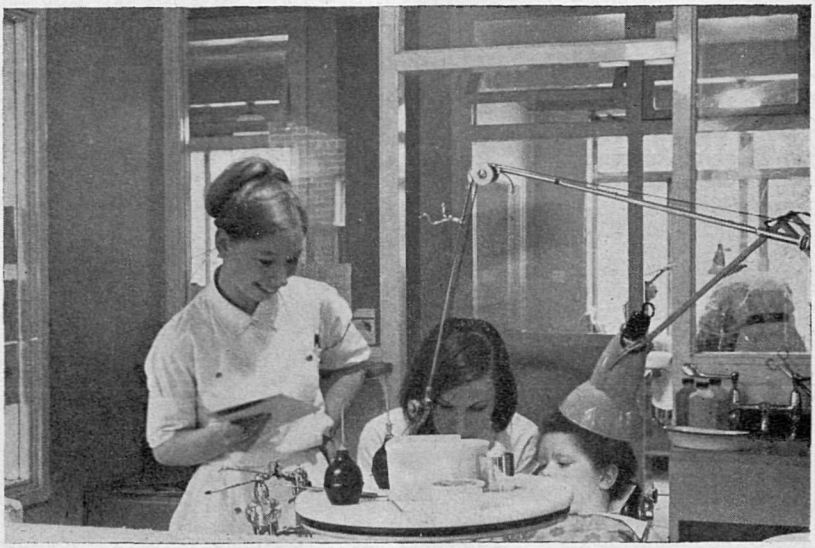


Fig. 2
A Dental Surgery.
A first year student acts as assistant to a second year student who treats a patient

Students are trained to extract deciduous teeth under infiltration local anaesthesia (anaesthesia not involving direct nerve blockage); to fill teeth in children of school age with amalgam and silicate restorative materials; to clean and polish and to scale teeth (remove tartar, calculus and stain from those surfaces of the teeth directly beneath the free margins of the gums); to apply topical solutions of fluoride and other similar prophylactic solutions where required, and to give general dental health instruction.

Having satisfactorily completed the course of instruction, the students are required to sit a terminal examination consisting of two two-hour written papers, a practical and an oral examination, this being carried out by external examiners. Students attaining the required standard are awarded a Certificate of Proficiency by the General Dental Council. As qualified Dental Auxiliaries they are then permitted to carry out such work in national and local authority health services throughout the British Isles. This work may only be carried out under the direction of a registered dental surgeon who has examined the patient and has planned the course of treatment to be provided.

In April 1960, sixty candidates were selected from the vast number that applied and this intake has been maintained each subsequent year. The requirements were, and are, that the candidate should have attained the age of 17 by the time of entry, and should have passed in at least four subjects in the Ordinary level examination of the General Certificate of Education, passes in English Language, Mathematics and science subjects being specially favoured.

	HOURS		
	Lectures	Practical	Clinical
Part 1			
1st Year			
General Anatomy	20	30	
Dental Anatomy	20	70	
Histology	10	10—20	
Physiology	40	30	
Operative Dental Surgery	50	120	
Oral Hygiene	10	150	
Hygiene (Communal and Personal Health)	8		
Chairside Instruction (Acting as assistant to 2nd year student) ...		400	
Part 2			
2nd Year			
General Pathology	20	10	
Bacteriology			
Pharmacology	10	—	
Dental Pathology	20	10	
Local Anaesthetics and Extractions ...	10		
Orthodontics	4		
Radiography	7		
Child Welfare	4		
Dental Health Education	26		
First Aid	4		
Law and Ethics	4		
Administration and Records ...	8		
Patient Management	4		
Operative Dental Surgery	20		600
Visits to Hospitals and Clinics ...			40
Tutorials	200		

Fig. 3

THE COURSE OF TRAINING FOR DENTAL AUXILIARIES
indicating the time allowed to each subject.

The first group of students entered the School on October 3rd, 1960 and, under the control of the Director, Mr. J. V. Bingay, with five dental surgeons and five tutors, started a rigorous course of training. The course is divided into two parts (Fig. 3).

The patients for treatment by the students are all children drawn from local authority schools. Treatment is not compulsory, and the parents of the children are all sent a circular offering a choice of three methods of treatment.

(i) To receive dental treatment at the Children's Dental Clinic at New Cross.

(ii) To make arrangements for the child to be treated by a dental practitioner.

(iii) The child to be given an appointment at one of the treatment centres of the Inner London Education Authority.

The children who elect to undergo treatment by auxiliaries are collected by coach from their respective schools, together with their parents where necessary, and are returned there following the treatment. Time is not a factor in the treatment of the children and a student may spend much time gaining the confidence of the patient. The surgeries are equipped with many toys purchased by the students themselves. Patients soon learn to face dentistry with equanimity. In this respect, therefore, the auxiliaries provide a valuable service

Fig. 4

THE DENTAL HEALTH EDUCATION ROOM.

Students design posters, games, models and toys to stimulate interest in Dental Health.

to the dental surgeon who will treat these patients in the future in that they will have become conditioned to accept dental treatment without any fear and will thus provide excellent material for subsequent dental work.

Apart from the valuable contribution to practical dentistry made by the auxiliaries, they also perform an important service in the furtherance of dental health education. At New Cross, each student spends about 26 hours producing posters, models, booklets, games and slogans promoting oral hygiene. Recent visitors to the School will have seen, on entering the Dental Health Education Room (Fig. 4), two large posters, one a Mary Poppins scene bearing the slogan "Clean teeth are supercalifragilisticexpialidocious" and a second depicting a somewhat molariform elephant holding a toothbrush with the poignant message, "An Elephant Never Forgets, Do You?" The posters are replaced by new ones at regular intervals, thus retaining and stimulating interest in dental health education. Perhaps the device which most fascinates the children is a ludo game, modified so that the start is represented by dental decay, and the finish—the ultimate goal, by complete dental fitness. Counters are replaced by models of toothbrushes and tubes of toothpaste. Standards of oral hygiene must surely be improved by such methods.

The success of the School must be reflected in the fact that the consent rate of children requiring dental treatment in the New Cross area has risen sharply. The consent rate, as measured by the number of children who accepted dental treatment, reached 72 per cent in 1966. Of the remaining 28 per cent, a high proportion are treated by local authority or private dental surgeons, leaving 5—6 per cent who seek casual treatment, only when in pain.

In due course a report on the training of auxiliaries was submitted by the General Dental Council to the Privy Council, who came to the conclusion that these auxiliaries were of use to the community, so that regulations determining their conditions of employment could be created.

Trained auxiliaries are now employed by over eighty local authorities, and by the end of 1966 there were approximately 250 girls at work throughout the British Isles. Some now work on children in dental hospitals, including three at the London Hospital, two at the Royal Dental Hospital and one at each of Birmingham and Manchester Dental Hospitals.

There are no plans to establish further schools for training dental auxiliaries in the immediate future, although no doubt in due course consideration will be given to the possibility of setting up other schools. This will depend, presumably, upon the ability of the local authorities throughout the British Isles to absorb and use to best advantage those trained at present.

Great Britain is not the only country to employ ancillary dental workers of this type. New Zealand has, for many years, had an auxiliary network of a similar nature spread throughout the land,

providing an invaluable service, especially in more remote areas. Auxiliaries also work in Ceylon, Malaya, Singapore and Queensland (Australia). In the Sudan, men of the auxiliary type are being trained, and plans have been formulated in Jamaica for such a system. Girls are being employed in the Yukon area of Canada, although as yet, they have no school. No plans for any system of this type exist anywhere in the United States of America.

The scheme to train dental auxiliaries has caused many misgivings amongst the dental profession and in some quarters the scheme has been vigorously opposed. However, due to the determination and energy of its proponents, auxiliaries are contributing to an efficient and effective Service for the provision of dental treatment for children, and there is no doubt that as the value of the Service becomes even more widely appreciated, the opposition of the profession will diminish.

References :

Interim Report on the Experimental Scheme for the training and employment of Dental Auxiliaries. General Dental Council, 1963.

Final Report on the Experimental Scheme for the training and employment of Dental Auxiliaries. General Dental Council, 1966.

Acknowledgment :

I should like to extend my thanks to Mr. J. V. Bingay, M.B.E., L.D.S., R.C.S., Director of the School for Dental Auxiliaries, for all his encouragement and assistance and without whose help this article could not have been produced.

QUIZETTE : Infectious Disease

1. Which of the following are known to be associated with Mycoplasma *pneumoniae infections?*
   (a) Urethritis; (b) Haemolytic anaemia; (c) Raised levels of immunoglobulin M; (d) A rising titre of cold agglutinins; (e) a raised anti-streptolysin O titre.
2. Which of the following are usually associated with the Landry-Guillain Barré syndrome?
   (a) High lymphocyte count in C.S.F.; (b) Prompt response to broad spectrum anti-biotics; (c) Complete spontaneous recovery; (d) Meningism; (e) Extensor plantar responses.

3. In which of the following diseases is a vesicular eruption in the mouth commonly seen?
(a) Chicken pox; (b) Herpangina; (c) Stevens-Johnson syndrome; (d) Geniculate herpes; (e) Measles.

4. Which of the following vaccines contain living micro-organisms?
(a) Small pox; (b) Pertussis; (c) T.A.B.; (d) Yellow fever; (e) Sabin.

5. A patient's C.S.F. is found to contain 250 cells/cu. mm. all of them lymphocytes. Protein is 60 mg%, Chloride 720 mg%, sugar 80 mg%, W.R. negative. With which of the following diseases is this compatible?
(a) Tuberculous meningitis; (b) Mumps meningitis; (c) Post measles encephalitis; (d) Tabes dorsalis; (e) Post infective polyneuritis. ...

6. A patient is suspected of having Bornholm's disease. From which of the following is the causative virus (probably a Coxsackie Group B) likely to be isolated?
(a) Faeces stored at room temperature; (b) Faeces stored at −20°C; (c) Blood; (d) Urine; (e) Throat swab, stored at 37°C.

7. On the fifth day of enteric fever, which of the following investigations are likely to be helpful in establishing the diagnosis?
(a) Vi agglutination titre; (b) Widal reaction; (c) Blood culture; (d) Weil-Felix reaction; (e) Culture of faeces.

8. Which of the following statements are true?
(a) A virus contains D.N.A. and R.N.A.; (b) Myoplasmas require living tissue for culture; (c) Bacterial L-forms do not occur naturally; (d) Brucella organisms require an atmosphere containing 10% CO_2 for culture; (e) The Waterhouse-Friedrichsen syndrome responds to steroids.

9. A patient with herpes zoster—
(a) Has never had chicken pox; (b) Has probably had chicken pox previously; (c) May simultaneously have chicken pox; (d) Has recently been in contact with a case of chicken pox; (e) May transmit chicken pox to others.

10. Delayed hypersensitivity is the basis of
(a) The Koch phenomenon; (b) The Arthus phenomenon; (c) The Mantoux reaction; (d) The Schultz-Charlton reaction; (e) The Döppler effect.

11. Which of the following are the treatments of choice for the diseases specified?
(a) Tetracyclines for typhus fever; (b) Ampicillin for typhoid fever; (c) idoxuridine for herpes simplex encephalitis; (d) chloramphenicol for haemophilus influenzae meningitis; (e) Penicillin for whooping cough.

12. Which of the following are transmitted by droplets from the upper respiratory tract?
(a) Meningococcal scepticaemia; (b) Rubella; (c) Infectious hepatitis; (d) gastro enteritis of infants; (e) cholera.

13. Which of the following are characteristic of glandular fever?
(a) Neutrophil leucocytosis; (b) The presence in serum of a heterophil agglutinin (c) Exudate on the tonsils; (d) Puffiness of eyelids; (e) Petechiae on palate.

14. Which of the following diseases are spread by insect vectors?
(a) Malaria; (b) Kala-azar; (c) Schistosomiasis; (d) Hook worms; (e) Rocky mountain spotted fever.

QUIZETTE ANSWERS

1. **(b), (c), (d)**

   Mycoplasma pneumoniae has not been found in association with urethritis. Most mycoplasma strains isolated from the genito-urinary tract have been identified as Mycoplasma hominis type I, and whether these organisms are responsible for inflammatory disease of the G.U. tract is still a matter of controvesy. The A.S.O. titre is not raised in mycoplasma pneumoniae infections, but in many cases a rising titre of streptococcus M.G. agglutinins can be demonstrated. [1], [2].

2. **(c)**

   The Landry-Guillain-Barré syndrome is basically a polyradiculopathy. While cranial nerves, particularly the seventh, may be affected, long tract signs do not develop. [3].

3. **(a), (b), (c), (d)**

   The Koplik's spots seen on the buccal mucosa, most commonly adjacent to the lower canines, during the first few days of measles (before and up to the morbilliform eruption on the 4th day) are not vesicular, but white spots of cellular debris, on an inflamed mucosa. Vesicles are commonly seen on the palate in chicken pox on the fauces in herpangina, on the gums in the Stevens-Johnson syndrome and on the anterior pillar of the fauces in geniculate herpes zoster.

4. **(a), (d), (e)**

5. **(b)**

   A pure lymphocyte response of this degree is seen only in mumps meningitis and benign lymphocytic choriomeningitis. Most other viral meningitis is associated with up to 20 per cent neutrophils in the C.S.F. in the acute phase. Tuberculous meningitis is associated with a mixed neutrophil and lymphocyte response, high protein (200-500 mg per cent) and low chloride (less than 620 mg per cent) whether or not the patient has been vomiting. The C.S.F. of polyneuritis classically contains much protein (300-400 mg per cent) and a normal number of cells (up to 2 lymphocytes/cu.mm) C.S.F. of tabes classically contains a slight increase in mononuclears, up to 70 per cu.mm., and a slight excess of protein. W.R. is negative in 30 per cent of the cases. In measles encephalitis there is a slight increase in lymphocytes (50-100) and variable but never very high protein.

6. **(b)**

   Faeces and throat swab for virological examination must be stored at low temperatures, the throat swab after immersion in a fluid medium. Virus particles have been isolated from urine but the techniques are difficult.

7. **(c)**

   Culture of faeces and urine, and the Widal reaction are usually not helpful until the second week. The Vi agglutination titre is only of value in assessing carrier states although not in areas where enteric fever is endemic. The Weil-Felix reaction is of value for the diagnosis of rickettsial diseases only.

8. **(d)**

   Viruses contain D.N.A. or R.N.A. but not both. [5]. Mycoplasma can be grown on cell free media provided certain organic substances such as sterols are present in the media. The original bacterial L-form (L for Lister Institute) was isolated from a rat [6], and grown under ordinary conditions for cultivation of Streptococcus moniliformis. The Waterhouse-Friedrichsen syndrome of meningococcal scepticaemia is now considered to be a generalised Schwarzman reaction rather than simple haemorrhagic adrenal failure.

9. **(b), (c), (e)**

   Herpes zoster is probably an eruption of neurotropic varicella virus lying dormant in the C.N.S. and "escaping" by virtue of altered immunity as seen in Hodgkins disease. A simultaneous sparse chicken pox eruption is seen in 30-50 per cent of cases [7], and such cases can readily transmit chicken pox to the non-immune. It is most unlikely that anyone has "caught" herpes zoster directly from a case of chicken pox.

10. **(a), (c)**

    The Arthus phenomenon is dependent on humoral factors, not on cellular immunity, an example being the reaction to horse serum following A.T.S. injections. The Schultz-Charlton reaction is a scarlatina toxin-antitoxin reaction, and the Döppler effect has nothing to do with infectious diseases.

11. **(a), (c)** [8], **(d)**

    It has been conclusively shown that chloramphenicol is more effective in typhoid fever than ampicillin. Penicillin is ineffective in pertussis, except as a prophylactic against secondary infection.

12. **(a), (b)**

    Infections hepatitis, infantile gastro-enteritis and cholera are all spread by the faecal-manual-oral route.

13. **(b), (c), (d), (e)**

    The blood picture in glandular fever commonly shows a monocytosis and lymphocytosis with many atypical cells.

14. **(a), (b), (e)**

    The larvae of Ankylostoma duodenale and the Cercariae of schistosoma usually enter the body via direct penetration of the skin.

REFERENCES

[1] Feizi, T. et al. Brit. Med. J., 1967, **1**, 457.
[2] Hayflick, L. and Chanock, R. M. Bact. Rev., 1965, **29**, 186.
[3] Guillain, G. Barré, J. A. and Strohl, A. Bull. Soc. Méd. Hôp. Paris, 1916, **40**, 1459.
[4] Brit. Med. J., 1967, **1**, 126.
[5] Brit. Med. J., 1966, **2**, 687.
[6] Klieneberger, E. J. Pathol, Bacteriol, 1935, **40**, 93.
[7] Personal series, unpublished.
[8] Calabrisi, P. Ann. N.Y. Acad. Sci., 1965, **130**, 192.

Compiled by Ian McGill.

MUSIC IN GUY'S

THE PAST.—The Music Circle presented a concert in the Nuffield Nurses' sitting room on Monday, July 3rd.

An admirably planned concert started with Mozart's beautiful piano Sonata K310, played by Miss Janet Higgs—her performance belied the fact she had been struggling with conjoint examiners all week. It was remarkable for its accuracy. Miss Higgs clearly takes a Beethovenian view of Mozart, hence there was no little power in her reading, which perhaps lacked a little in delicacy. No such criticism could be made of her playing of a rondo on folk tunes by Bartok. Her romantic playing of the charming melody, coupled with her percussive technique where necessary, made exciting listening.

After wine and cheese served in the interval, one was prepared to enjoy almost anything. "The Six Faces of Love" was a superb entertainment. Clavicord, spinet, counter-tenor, soprano, bass, madrigal chorus plus two members of the Theatre Club combined. Stephen Coles is to be warmly congratulated not only on the excellent musical performances but also for having devised the whole, including the poetry. We heard of "Desire": here the madrigal group produced perfect diction. Miss Judith Bennett's Guy's swan song was by Purcell on "Unrequited Love": her voice will be sorely missed. "Joy" included "Drink to me only with thine eyes." "Truth" brought a humorous and authoritative rendering of "Sylvia, the fair, in the bloom of 15," by Dryden: it sounded almost pure rather than bawdy and pornographic. The final two faces were of "Sorrow" and "Parting"—here Sarah Large read a poem by George Herbert. Once again we appreciated John Dudley's counter-tenor—perhaps he showed us even finer singing in his tenor rôle.

The total artistic success was well appreciated by a sizeable audience and we can only hope for more!

FUTURE.—The Music Circle hopes that Mr. Bernard Miles (of Mermaid Theatre fame) will be paying a visit in September. Also, later on, Delme Bryn-Jones, a principal tenor at Covent Garden currently appearing as Masetto, will be giving a talk.

For the native singers, Gilbert and Sullivan rehearsals will soon be in full swing: anybody else interested, please contact Mr. Nigel Winter via Pigeon Hole, East Wing.

One hears, via the grape vine, that Christmas might well see a Haydn mass performed in Southwark Cathedral under Mr. Stephen Coles' direction —either the Nelson or Harmonium esse (Wind Band Mass).

HEDLEY BERRY

CORRESPONDENCE

A Matter of Life and Life

SIR,—There are more questions here than money priority. As just one such question, Medical (and general scientific) manpower. In some parts of the U.K., one G.P. has total responsibility for 5,000 patients. Just how many kidney machine patients can be looked after by one physician? Could this man possibly be better employed by deployment in General Practice?

At the moment this question is theoretical, and may seem far-fetched; but how long will it be before increasing Doctor shortage will bring direction of medical manpower within the realm of practical politics?

Yours, etc.,

E. L. LONBAY

"Craythornes",
New Romney, Kent.

Old Question—New Answer?

SIR,—Publicity for the consumption of more milk has been going on for several years.

As a layman interested for many years in medicine, but not a hypochondriac, I should welcome an authoritative opinion on whether milk contains enough animal fat to cause cholesterol in the blood and therefore to expose heavy consumers to a hazard. I appreciate that age, amount of exercise and creaminess of milk are factors.

Yours, etc.,

BERNARD COULTER.

The Chestnuts,
Thorndon, Eye, Suffolk.

Super White Coats

SIR,—Further to Mr. Peter Hudson's letter concerning the advantages of white coats to students, may I suggest the following points.

The large pockets of the coats will enable one to carry a spare supply of pink, green and blue investigation request forms, which always seem to be missing. A slightly larger pocket will be needed to take "to's and fro's". (My mother says this can easily be made.)

By experimenting, I have found that cotton wool balls pushed under the collar stay there until required; if you carry your pen in your trouser pocket/handbag a bottle of ether meths fits snugly into the top outer pocket. A rubber band tied between the backs of two buttons enables spare sequestrene and lithuim heparin bottles to be tucked tidily out of sight.

At most other hospitals where white coats are worn such improvements are not yet employed; in this field surely Guy's can step ahead.

Yours, etc.,

RICHARD CHISWELL

East Wing,
Guy's Hospital.

REVIEWS

ADVANCES IN DENTAL HISTOLOGY.

W. A. Gaunt, J. W. Osborn, A. R. Ten Cate, John Wright and Sons, Ltd., Bristol. 1967. 104 pp. *Price* 19*s*. 6*d*.

This book is the sixth in the series of Dental Practitioner Handbooks published by John Wright and Sons Ltd., of Bristol, and undoubtedly fills an important gap in the literature on the subject of oral biology.

The authors, all of whom are teachers in the Department of Anatomy at Guy's Hospital, with responsibility for the teaching of Dental Students, affirm that this book is not an orthodox textbook of dental anatomy. Rather, they have aimed to review latest advances and concepts in a critical and least dogmatic manner. No one will question their success, for in a simple, lucid and most refreshing style of presentation, the reader is introduced almost without realising it to the most up-to-date views on such subjects as osteogenesis, cementogenesis and amalogenesis. Virtually every facet of tooth and supporting tissue biology receives attention, and, in addition, two most valuable general chapters are included; one is concerned with methods of investigation of oral tissues and the other deals with the cell. All this has been compressed into less than 100 pages of text.

On first glance through the book the abundance of line drawings rather reminds one of the old type medical textbook published before the techniques for reproduction of photographs were perfected. However, closer inspection reveals that these drawings are of extremely good quality and have been used with great skill and care to shorten and simplify what would otherwise have been highly complex descriptions in the text. The use of such diagrams permits rapid revision and has no doubt contributed to the modest cost. Further, they are of the type that students will easily remember and be able to reproduce to advantage in examinations.

At the end of most chapters a number of the principal references on the particular subjects covered are given. These have been chosen with care not only because they are the most up-to-date authoritative papers on the subject, but because they are published in journals which are readily available in all dental libraries.

There is no doubt this book will be highly successful and can be recommended without reserve to practitioners who wish to keep abreast with current advances, and to undergraduates and primary F.D.S. candidates who desire to know more than the bare essentials of the subject.

M. N. NAYLOR

A TEXTBOOK OF MEDICAL CONDITIONS FOR PHYSIOTHERAPISTS

(3rd Ed.), by Joan E. Cash, B.A. M.C.S.P.(T.), F.C.S.P.(Hon.). Faber & Faber, 1965. Pp. 281, illustrated. *Price* 32*s*. 6*d*.

Like its companion volume on surgical conditions, this edition has been extensively revised and contributions have been made by physiotherapists specialising in particular fields. This has led to an increase in depth and avoided monotony of style but has caused some repetition in the introductory chapters of the various sections.

The revision of the first section, dealing with pathological changes, has been less drastic and it has a faintly old-fashioned air in the inclusion of some outmoded forms of treatment, but generally the tone of the book is more realistic and purposeful than in previous editions.

The greatest space is given to nervous conditions, and includes excellent chapters on cord lesions, cerebral palsy and hemiplegia, in which the importance of early movement and ambulation is stressed. As in all other sections, there is a good introduction explaining the presenting signs and symptoms, and the principles of treatment based on a detailed examination to supplement a preliminary study of the case-notes.

The Rheumatic conditions section contains brief descriptions of the conditions less commonly seen in the physiotherapy department, and sensibly devotes most space to O.A., R.A., and spondylosis emphasizing the fundamental need to show the patient how best to help himself, and to make maximum use of remaining joint function in terms of living requirements. Some explanation of the significance of blood-tests could have been usefully included. Similarly, in describing the treatment of respiratory diseases, an account of respiratory function tests would have been of value.

Other sections deal more briefly with skin diseases and paediatrics, and the final chapter summarises the management of physical disability in relation to daily living activities, sport, education and industrial rehabilitation.

Its clear statement of the principles of treatment has made this a valuable textbook for students since its first publication in 1951. The illustrations and clear lay-out and the greater detail of the edition will ensure its continued popularity among physiotherapists, and it merits attention from all those concerned with physical treatment.

RONALD COOPER

NURSING SECTION

Profession or Service?

"Oh, you are a nurse? Well, you must have a vocation for it. I couldn't do it!" How many have had this said to them at some time or another, and how many nurses wonder if it is true. Is this field that we are working in a profession or a service? Are we truly a professional body or are we servants to the medical profession?

To trace the history of when Nursing first called itself a profession one must go back to about the turn of the century. Nurse training was at that time well established following the Crimean War. An ex-Matron of St. Bartholomey's Hospital called Mrs. Bedford Fenwick formed the British Nurses Association and also the National Council of Nurses. This led to the formation of the College of Nursing in 1916, and nursing became a registered profession, and in 1919 the General Nursing Council was set up and empowered to open and maintain a register of nurses. In the following years until the end of the 1930's modifications were introduced—nursing became more stereotyped and educational standards, training school regulations and entrance to Register examinations were set up.

Thus the Nursing Profession gradually evolved and nurses today call themselves members of a professional body. Allowances are made for student nurses and by being members of the Student Nurses Association they are registered, before qualification as being associate members of the professional body.

A Service is defined as work done for another, benefit conferred on another or exertion made for another. As work done for another, nursing is actually working for the medical profession. There is little done without the approval of the doctor in charge of the case and in many spheres nursing can be seen as merely a fetch and carry service for the Medical profession. As an exertion made for another then nursing is surely so, with regard to patient care. All exertions made by nurses are in effect to one end—the care of the patient.

Are nurses subservient to the medical profession or are we merely in close conjunction and not really dependent on our medical colleagues?

Many of the nursing standards are set down by representatives of the Medical profession and they are members of the committees of both the General Nursing Council and the Royal college of Nursing. The examinations set for the Register are set both by nurses and by doctors and are marked by the same.

Thus we call ourselves professional people and thus also we are performing a service. We could be very near to a union and if one was ever formed nursing would become a service only—it would also destroy professionalism. The ordinary nurse probably does feel professional. Those who have become more disillusioned about nursing probably think of themselves as servants anyway—especially when they perforce must carry out domestic duties and slave over large masses of paperwork.

Members of a profession or performers of a service is something which each nurse must clarify in her own mind. Whether she does this in her day-to-day work or by representation to her regulating body is something which will be her own affair.

STAFF CHANGES AND APPOINTMENTS

NEW APPOINTMENTS

Sister M. Baxter (Guy's 1961- 1966) to Outpatients Department (promoted from C/N).
S/N K. LaReau (Johns Hopkins Hospital, Baltimore, U.S.A.) to Outpatients Department.

RESIGNATIONS

S/N D. Bratley from Miriam Ward.
S/N J. Craven from Nuffield B Floor.
C/N M. Gordon from Relief Night Duty.
S/N A. McKnight from Martha Ward.
S/N H. Spring from School of Nursing, Introductory Course.
S/N N. Tierney from Main Theatres.
S/N J. Wiltshire from Naaman Ward.

SPORT

CRICKET

The Mote beat Guy's by seven wickets. Despite a slow over rate by The Mote, Guy's eventually declared at 214 for 7 after R. Clark had made 80, P. Swift 30 and M. Appleby 27. In reply, The Mote were not harassed by the Guy's bowlers and at 215 for 3 had completed the chore. (M. Bristow 72; M. Appleby 2 for 81.)

Against U.C.S. Old Boys only Chase with 53 showed any ability to play a wet but fastly drying wicket, upon which U.C.S.O.B. eventually won by 8 wickets.

Guy's perhaps encountered a demoralising display of club cricket sportsmanship when playing Mayfair.

Mayfair, electing to bat, made a total of 155. However, some fine bowling by C. Pearson (5—33) had helped to dismiss the majority of the Mayfair wickets reasonably rapidly, but a prolonged stubborn defensive batting performance by the remaining three Mayfair batsmen produced a situation of Guy's having bowled 57 overs were left with just under two hours (and eventually in 37 overs) to reply. Guy's, somewhat weaker than usual, showed no hope of producing any result but a draw.

Playing Wallington re-instated confidence and interest in cricket. In a match producing 500 runs, Wallington batting first declared at 253 for 6, the Wallington skipper scoring a century before being bowled by Appleby (who in conjunction with Davies managed to contain—to some extent—the other Wallington batsmen).

Although we must comment that the combination of a fast wicket, a short boundary and a fast out-field greatly facilitated large scores, it is still with credit that Guy's mustered 255 for 9 in reply. Guy's had lost two wickets for 50, but a fine partnership by Swift and Appleby of 140 runs in 60 minutes laid the foundation for a Guy's victory that balanced on a razor's edge when Beacham and Davies were left at the wicket to complete the performance. An overthrow from a Wallington fielder saved the day!

ATHLETICS—A.A.A. CHAMPIONSHIPS

I. Morgan, returning a personal best time of 53.1 secs. for the 440 yards hurdles and the third fastest time in the heats of this event, failed to qualify for the final, as the third place he gained was not adequate for an event in which only the first two of each heat qualify.

Of the two competitors faster than Morgan in his heat:—J. Sherwood (Birchfield H.) who won the event in 50.9 secs.—a U.K. National & A.A.A. National record, equals championship best— and P. Warden (Airedale & Splen Valley) who came third in 52.1 secs. It is intriguing that John Cooper the Silver Medallist in the 1964 Tokyo Olympics came 5th in 53.1 secs!

UNITED HOSPITALS R.F.C.

At the A.G.M. held at Guy's, Mr. T. L. T. Lewis, the President, took the chair.

The following officers were elected for 1967-68 season:—

Captain: P. G. F. Swift (Guy's)
Vice-Captain: T. M. Rutter (Westminster)
Hon. Secretary: J. F. Price (Guy's)
Assist. Secretary: K. McIntyre (Bart's)

Colours were awarded to the following Guy's players:—

J. M. Cockburn, D. R. Elliott, G. B. Hey, C. G. Neville, J. R. M. Ross, B. J. Rowlands, P. G. F. Swift, C. W. Thorburn.

Also played: K. Brown, M. J. Cheeseborough, D. A. Curson, J. E. Davies, A. J. Kingdon, J. F. Price, H. C. Sharp, P. A. L. Williams.

Next season, we should note, is the U.H. Centenary Year when the Club is planning to arrange a fixture against an Invitation XV, comprised of past U.H. players and prominent club players.

DIARY

CRICKET

July 22.—Metropolitan Police. 2.30. Away.
July 23.—London New Zealand. 2.30.
July 29.—Lloyds Bank. 2.00. Home.
July 30.—Enigmas. 2.00. Home.

Yours, etc.,

CRICKET

JUNIOR CUP FINAL

Played at H.O.P. 4-7-67

Lost by 5 runs.

Guy's lost the toss and Mary's naturally decided to bat as the competition is run on similar lines to those of the Gillette Knock-out Competitions; i.e. 40 overs each but there is no limit to the number of overs any one bowler may bowl.

The opening partnership put on only eleven runs when Fordham bowled one of the Mary's openers with a very good ball in his second over. He continued to bowl well and claimed another two wickets to have Mary's 3 for 33. However, Isserun, the other opener was still there and having been dropped twice went on to make a final 75. Also Simpson, their No. 5, was dropped off his first ball and then went on to make 69. These mistakes were very costly as the next wicket fell at 166 when Isserun was run out. Fordham then bowled Simpson when the score was 170 and the remaining overs were played out, Mary's closing at 185 for 5.

After tea the Guy's openers, Gillham and Thomas, set about the bowling and the first two overs realised ten runs—just above the rate of 4.5 required for victory. This rate was maintained throughout the innings and wickets were lost, especially to the spinners, by people trying to force the score along. Copeland, the Mary's captain, held two fine catches to dismiss Barford and Elliott who both looked as if they were beginning to get going. W. W. Davies and Neville however, got together and stabilised the lower half of the order. Davies went on to a fine 54 despite losses at the other end. He was eventually out when only six runs were needed for victory. There were now only eight balls left but unfortunately Kendrick was bowled off his pads by the second ball of the last over and so the Cup passed to Mary's by 5 runs.

We lost the game to a better side but had a very good game of cricket, 365 runs being scored in just under eighty overs.

Finally I would like to thank all those who supported us, R. Beacham and M. Knight who umpired, the latter also having subsituted for W. Davies who was late arriving from a medical finals viva, which he passed.

R. W. KENDRICK

Mary's: 185 for 5 (Isserun 75 Simpson 69 Fordham 4-65)
Guy's: 180. (W. W. Davies 54).

GUY'S v. THE MOTE

Result: The Mote won by 7 wickets.

Guy's: 214 for 7 dec. (R. Clark 80, P. Swift 30* M. Appleby 27).
THE MOTE: 215 for 3 (M. Bristow 72*, M. Appleby 2 for 81).

It is hoped that following the correspondence in a recent edition of the Gazette, the Sports Editor will have recognised his gross error of judgment in commenting on a sport about which he clearly possesses very little knowledge, and will have published an apology, or at least will have confined himself to the traditional resumé of sport in general in his latest editorial.

The following report is offered as one which might be suitable for the new "controversial" "unsationalist" Gazette reminiscent in parts of a certain section of the popular Press.

Pacement, Page, and Biggs, of the Mote bowled at the "go-slow" over rate of only 15 overs in the first hour. Although Bob Clark, Guy's number 3 batting star, hammered 80 before being run out, Guy's did not catch up with the clock until skipper Mike Appleby and wicket-keeper Pete Swift came together in a big hitting, bustling partnership enabling a declaration to be made at 214 for 7.

Crafts and Swingman Dick Beacham were unable to break the Mote defences and it was not until Mike Appleby—this time playing the role of leg tweaker—came on to bowl that the first wicket fell. However, Mike Bristow batted with such assurance that although the Guy's bowlers and fielders toiled cheerfully in the sun, their total was overtaken in a storming finish minutes before stumps.

NB.—The above facts have been distorted and exaggerated and are not guaranteed to bear any recognisable resemblance to what actually happened, although they may by coincidence do so.

Soccer Correspondent

GUY'S v. MAYFAIR C.C.

Match: Drawn

Mayfair C.C.: 155, (C. Pearson 5 for 33).
Guy's: 108 for 7 (Butchey 44).

As a result of members being on take-in and on holiday the first XI fielded a weakened side to play Mayfair. Joe Butchey captained the side for the first time and his wife and small son were present at H.O.P. to witness the great occasion. To record a win was the captain's prime intention but the pathetic efforts of the opposition batsmen, the poor Guy's catching (alas—a common failing), and the incredible "declaration" of the Mayfair captain combined to thwart Butchey's ideas and to successfully kill the match.

The Guy's skipper lost the toss and Mayfair decided to bat on a good batting wicket. The afternoon sun was hot, the opening attack toiled for an hour, and three easy catches were dropped by the slips. (Our specialist was sadly missed.)

The Mayfair batsmen either successfully found the edge or played and missed. The spinners, Davoodbhoy and Pearson, replaced the seamers, Davies and Beacham, who were,

despatched to the boundary to ponder on missed chances and with analysis that showed little resemblance to their performance.

Wickets, however soon began to fall. At ten to five the last three Mayfair batsmen decided, enviously, that defence and survival at the wicket was better than any attack, whatsoever. The last wicket fell at 5.14. after 2 hours 40 minutes batting for 155 runs. We had bowled 57 overs, Pearson captured 5 wickets for 33 runs in a good spell of spin bowling.

The Mayfair captain probably remembering the match last year in which Butchey scored a very quick 'ton' decided to reduce our batting time by 45 minutes less than that of his own side.

After tea the Guy's opening batsmen applied themselves to the task slowly but surely. Butchey was not in the same form as last year but accumulated 44 runs to give the batting a reasonable foundation. The rest of the batsmen failed, except for Chase, in their efforts to push the score along. The inevitable result was a draw. It would have taken a far better side to have scored the required runs in the time given to us and with the opposition bowling 20 less overs.

The match was a bore and a big disappointment to the number of Guy's supporters that were present—a pleasant change this. Butchey captained the side well, but faced impossible odds and the victory he wanted was not attained.

R. BEACHAM

GUY'S v. WALLINGTON

Away.

Wallington: 253—6

Guy's: 255—9 (Swift 93 Appleby 61)

Guy's first game against Wallington in their cricket week proved to be a resounding success. Guy's were forced to field on a very hot morning and before long it was obvious that a combination of hard fast wicket and short boundary would produce a glut of runs. By lunch with the score at 120-2 it seemed Wallington were set for a very large score. Inspired a hearty lunch the Wallington skipper soon reached his personal century at the expense of the Guy's slow bowlers before he was bowled by Appleby. The remaining batsmen were more restrained and due to a spell of accurate bowling by Appleby and Davies the score was kept down to 253.

Guy's were left 160 minutes to get the required runs. With only two hours left Guy's had lost two wickets for fifty runs. Two hundred runs at this stage seemed a very tall order, however, when Appleby joined Swift the position rapidly changed. Swift was at his best playing a faultless innings of 93 smiting the ball all over the ground. Appleby at the other end started uneasily but soon joined in the onslaught He was eventually caught on the boundary ending a share of 140 in 60 minutes Guy's were left with 60 to get in the last 45 minutes and two wickets were lost without addition to the score leaving Swift and Thompson together. Swift unfortunately was out shortly after the 200 was up. Davies found Thompson and together batting sensibly they pushed the score along. When, however, Thompson was out things looked black and shortly after when Beacham strode to the wicket things looked even blacker. In the last over Davies scored a single bringing Beacham to the strike and the spectators' hearts to their mouths; fortunately, an understanding fielder appreciated the situation and promptly provided four overthrows and so the game was won without Beacham troubling the scorers.

Of the many hard, clean-fought games this season this game must be one of the most rewarding. The effort of scoring 500 runs in a day leaves both sides with a gigantic thirst which was duly quenched.

HOSPITAL INFORMATION

APPOINTMENTS VACANT

Applications are invited for the following **Dental House Surgeon Appointment** for the period July 15th, 1967 to January 14, 1968.

General Duties, 1 vacancy

Applications should be sent to the Superintendent, Guy's Hospital, London, S.E.1. within one week.

Applications are invited for the following **Assistant Dental House Surgeon** appointments to commence as soon as possible.

General Duties, 1 vacancy
Preventive Dentistry, 1 vacancy

Applications should be sent to the Superintendent, Guy's Hospital, London, S.E.1. immediately.

Candidates may apply for either of the posts and should indicate their preference.

7th July, 1967.

The following house appointments, due to commence September 1st, 1967, are open to pre-registration candidates. Applications should be submitted to the Superintendent not later than **July 28th, 1967.**

BECKENHAM HOSPITAL
House Surgeon 1

MILLER HOSPITAL
House Surgeon 1

HITHER GREEN HOSPITAL
House Physician 1

LEWISHAM HOSPITAL
House Surgeon 1

PEMBURY HOSPITAL
House Physician 1

ORPINGTON HOSPITAL
House Surgeon 1

P. J. HELLIWELL
Superintendent

CHANGES OF ADDRESS

Mr. Arnold Alcock 337b Stroud Road, Tuffley, Gloucester. Telephone 20143

Dr. and Mrs D. G. Bancroft, 43, Conway Street, Lismore, N.S.W., Australia.

David and Ann Orme-Smith (née Ridley) Lion Hill, Tadworth, Surrey. (Telephone Burgh Heath 50397)

PERSONAL

BEDFORD—Excellent opportunity to join young Guy's group practice in this busy county town, Expenses—shared partnership offered after short introductory period. Willis, Goddard and Burton, Bedford.

FOR SALE—Triumph Herald 12/50 Saloon (1966). Good condition, 13,000 miles. £550 o.n.o. Telephone 01-894 3116, or Box No. 7/1

GUY'S MAN—Seeks an Assistant for West End Dental Practice. Telephone WELbeck 9433, or Box No 7/2.

TO LET—Large furnished 2-bedroom flat. Suitable for married couple. Easy reach Central London. Telephone 01-894 3116, or Box No. 7/1

BIRTH

DAVIES—On 4th April, at Midsomer Norton to Judy (née Ellis) and John Graham, a son, Benjamin Charles Graham, brother to Caroline and Matthew.

DEATH

RHYS-JONES—On May 29, 1967, Llwelyn Rhys-Jones M.RC.S., L.R.C.P., aged 73 years.

Attention is drawn to the fact that the "Gazette" is now available at a reduced subscription rate of £1 1s. 0d. p.a. for the first three years after qualification.

We would like to remind our readers that all copy for inclusion in the Gazette must be received eight days before the publication date.

Personal notices one shilling per word (Minimum £1. 1s. 0d.)
Birth, Marriage, Death and Change of Address notices are without charge to subscribers.
Non-subscribers will pay £1. 1s. 0d. for all notices other than Personal.

GUY'S HOSPITAL GAZETTE

EDITORS D. S. ROBINS and C. B. BROWN
SPORTS CORRESPONDENT J. G. PAYNE
NURSING CORRESPONDENT E. A. MALPAS

FORTNIGHTLY TWO SHILLINGS VOLUME 81 NUMBER 2062

The opinions expressed in these columns are solely those of their authors and are not to be taken as the views of the Hospital as a whole.

PASSIM

Postgraduate Meetings

During the last year there has been a remarkable proliferation of postgraduate meetings at Guy's. Apart from the Monday Registrars' meetings and the Wednesday Residents' meetings, many departments have organised regular clinical meetings, taking place at lunch-time or in the evenings. There have been cardiac, nephrology, respiratory, X-ray and other weekly meetings open to all hospital staff.

This welcome addition to the hospital's life was long overdue. It was extraordinary that so few organised occasions existed previously for the exchange of ideas and knowledge amongst those of registrar status, especially considering that there were almost as many of these people in the hospital and medical school as there were clinical students. Such meetings are of inestimable value, particularly as medicine becomes more and more esoteric in its advances and application, and those few who have taken on the unenviable task of organising the meetings are to be congratulated and thanked for the success of the meetings.

One sorry note, however, must be made. The innovation of the joint Residents/G.P's. monthly evening meetings promised much, a promise fulfilled by the keen G.P. attendance. As hosts, however, the Residents were guilty of what must be considered little short of poor manners. Yet again there were only a mere handful present, and once again they were greatly outnumbered by their G.P. guests. Their failure to appreciate that the good G.P. has so much to offer in discussion will do little to help stamp out the unrealistic sense of superiority that the hospital doctor is so often brought up to feel with respect to the G.P. Time off may be valuable, indeed it is, but the use of such a small part of off-duty time for the furtherance of the educational value of their pre-registration period quite apart from the routine daily running of their firms is one which many Residents would do well to consider equally valuable.

Potty

Everyone just stop a minute, regain cerebral control and use the mental faculties which have taken aeons to evolve and so try to analyse the "pot" problem (cannabis, hashish, marijuana).

The banner headlines in many nationals lately remind one of that old unkempt man who trudges around Leicester Square on Saturday nights with a placard bearing the emblazoned inscription—"The End is near"—. He's been there for the last sixty years and the world, we must report, has apparently survived the prophecy.

This mass Puritanical hysteria which is being whipped up throughout the country, appealing to the most base and irrational elements of the individual intellect is unbecoming, unsafe and very un-English.

Like the Medes and the Persians, the Greeks and the Romans, the British Empire has all but in name, crumbled to nothingness. Our industrial wealth and power, once the mightiest, is now pleading for quarter in a field where none is given. The importance of problems at home have been magnified and blamed for our failures abroad. So we have become overwhelmingly introspective and critical, especially of the activities of our young. One can see the beginnings of a puritanical backlash to some of the excesses of the irresponsible, of which the latter is not any more a twentieth-century phenomenon than reading the Bible.

There is nothing more pathetic than seeing a scorpion stinging itself to death when encircled by flames, without any attempt to save itself.

The arguments for and against the legalization of "pot" have been so bandied about as to present a picture of total chaos and confusion as to what arguments are valid or invalid, whose figures are true and whose false and whether interests are personal, vested or objective.

In the main, laws are passed either to prevent individuals harming others, or harming themselves. Of the latter, the crime of attempted suicide is an example. This has, in fact, been recently reversed, the argument being that it contravened certain basic principles of individual free will not directly involving others. The same may be said in the taking of "pot", so long as the person taking it does not, under its influence, cause harm or endanger others, the person taking it should be governed by the same laws as those who drink alcoholic beverages.

As yet there is no conclusive evidence as to the addictive, if any, powers of "pot", i.e. physical dependence, which could be a burden to the State. Anyhow, in this country a man may become an alcoholic if he wants, or allow himself a greater chance of contracting cancer of the lung from smoking, or bankrupting himself and his family from betting, and in addition he may make revenue from these vices.

Yet everyone is up in arms about a non-toxic pleasure-giving pull at "pot", because in the main it is not traditionally accepted as an English vice, and like most other things youth attempts it is thought that the main purpose is to increase the libido, deteriorate one's moral sense and allow one to become an orgaistic hedonist.

What absolute cant. If there are to be laws let them not be discriminatory—either tobacco, alcohol and pot—or outlaw the lot. A man who takes drink is not necessarily an alcoholic, one who smokes a chain-smoker, or one who takes pot an addict. Let people decide for themselves what they drink or smoke so long as they do not harm others.

Dr. Hugh Barker

The 90th birthday of Dr. Hugh Barber, of Derby, occurred on the 5th of July. It was a particularly noteworthy occasion. Dr. Barber was the first person to recognise and describe Renal Rickets and wrote the first authoritative paper on Traumatic Heart Disease.

As a general physician practising in Derby he had an international reputation aided, if only in small part, by his frequent sharing of his experience, wisdom and wit with Guy's men through his communications to the *Gazette*. A further claim to distinction lay in his playing cricket for Yorkshire and, in fact, representing three counties in three different sports during his student days, a feat that cannot be the achievement of many physicians.

On his birthday a dinner was given in his honour by his past and present colleagues at Derby. Our representative, who took with him the good wishes of Guy's, reports that Dr. Barber presided at this dinner in his usual upright, spritely, dignified and witty manner and in particular was very tolerant of the many eulogies and expressions of gratitude for help and encouragement made by his younger colleagues. This characteristic modesty was evident by what might have been considered his unspoken words: "It is very kind of you to make this fuss, and I suppose one has to have this kind of thing on one's 90th birthday." On behalf of his many Guy's friends and admirers we in post-dated turn would like to add our congratulations and good wishes to one for whom it is difficult to find a competitor for the title of the most distinguished living Guy's physician.

GUY'S DIARY

We offer our warmest congratulations to Mr. Ian McColl, who has been appointed Reader in Surgery and Surgeon to St. Bartholomew's Hospital.

HAEMATOLOGY AT GUY'S

by

P. Barkhan

The Department of Haematology consists of the haematology laboratory in Hunts House and the Blood Transfusion Unit in New Guy's House.

Apart from the routine haematological work of the hospital (which is now largely performed in the Hunts House laboratory) and teaching, the members of the department also carry out experimental work. The following is a brief outline of the main research projects under way.

I. PLATELETS. (P. Barkhan and J. King.)

(a) Platelet survival studies in man using diisopropylphosphorofluoridate ($DF^{32}P$) as a labelling agent.

Since platelets are easily damaged by in vitro manipulations, methods by which platelets can be labelled directly in vivo are preferable to those which involve removal of platelets from the circulation and subsequent re-injection. With suitable precautions, $DF^{32}P$ can be injected intravenously and will label all the circulating blood cells. By removing blood samples at intervals after injection, the platelets can be separated from the red and white cells by differential centrifugation, and their radioactivity determined. In this way a curve of platelet survival can be obtained and this will give by appropriate methods mean platelet life span. Two important and unresolved problems in this field are firstly, the precise shape of the normal platelet survival curve, and secondly the factors which determine the length of time for which platelets circulate. $DF^{32}P$ has been used to investigate some of these problems since it appeared to be an "ideal" cell label, i.e. was not eluted from the cell and was not re-utilised. During the course of this work special attention has been paid to the prolonged tailing which is evident in the $DF^{32}P$ platelet survival curves. This appears to be due, at least in part, to incorporation of ^{32}P into platelet phospholipids. Studies have shown that all the phospholipid fractions become labelled and the mechanisms of this incorporation remains to be elucidated. It will be necessary to label platelets simultaneously with ^{51}Cr and $DF^{32}P$ to assess the significance of the finding of ^{32}P "re-ultilisation". An

attempt is also being made to find out how $DF^{32}P$ binds to the platelet.

(b) **Measurement of platelet adhesiveness and aggregation.** These properties of platelets appear to be important in haemostasis and thrombosis. Apart from changes in various pathological conditions, particularly in those patients with unexplained abnormalities of haemostasis and in myeloproliferative disorders, interest also centres on the effect of various drugs.

2. VITAMIN K METABOLISM. (P. Barkhan and M. J. Shearer.)

A study has recently been started to investigate certain aspects of vitamin K metabolism in man. Surprisingly little accurate information in this field is available for man. It is hoped to devise a chemical method for assaying vitamin K in plasma, tissues and food. Special attention is being paid to the availability of vitamin K from the gut, the mechanism of transport of vitamin K in the plasma, the tissue sites of deposition, particularly the liver, and the effect of oral anticoagulant drugs. An ultimate object of this study is to investigate the way in which vitamin K is concerned with the bio-synthesis in the liver cell of four coagulation factors—Factors II (prothrombin), VII, IX and X. At the moment, work is confined to the problem of vitamin K assay in biological materials.

3. **ASSAY OF VITAMIN B_{12} IN SERUM.** (J. L. Raven).

Dr. J. L. Raven has been working on a radio-isotopic method for the assay of vitamin B_{12} in serum. Until recently, vitamin B_{12} was determined microbiologically and while this is a very sensitive and useful method of assay it is time-consuming—the lactobacillus leichmannii assay takes three days and that using euglena gracilis takes five days. With the radio-isotope method a result can be obtained in a few hours. A relatively simple and rapid method has been devised, the results of which compare favourably with those obtained by microbiological procedures. The method should lend itself to large-scale automation.

4. INTRINSIC FACTOR ANTIBODIES IN PERNICIOUS ANAEMIA. (J. L. Raven).

A large number of patients with pernicious anaemia and related diseases are being screened for the presence of serum antibodies to intrinsic factor with a view to assessing the significance of these antibodies in the pathogenesis of the disease. Several patients with high titres of antibody in their serum but without other evidence of the disease have been detected. It is hoped to investigate the cellular source of these antibodies and if possible to purify the antibodies and use them to isolate and purify intrinsic factor from human gastric juice.

The work which has been briefly outlined will give some idea of the research interests of the department and mention must be made of the important financial support which is being provided from the Hospital Endowment Fund, the Medical School, the Ministry of Health and the Wellcome Trust.

MORBID ANATOMY IN OLD AGE

A Pathologist's Report on a Survey of 1,713 Post Mortems on Patients of 70 years and over

by

Jane M. Fullerton

Consultant Pathologist,
St. Olave's and New Cross Hospitals.

The problem of old age is not new nor geriatrics a figment of a Welfare State—old age was obviously a problem in Old Testament days to quote the Psalmist. . . .

> "The days of our age are three score years and ten and though men be so strong that they come to four score years yet is their strength then but labour and sorrow, so soon passeth away and we are gone."

Later in the saga we hear Euripedes saying, "Youth is always dear to me. Old age is a load that lies more heavily on the head than the rocks of Etna." Yet the Greeks, although recognising and sympathising with such complaints, did not treat them as if they were universally valid—in fact, Socrates fought at the Battle of Amphipolis in 422 B.C. at the age of 47, and this was not unusual as Greeks were expected to serve in war until 60. This implies a high level of health and is confirmed by long years of useful life. Sophocles died at 90, Plato 82, Gorgies at over 100 years and all were busy to the last, even though Sophocles complained that "all evils are ingrained in long old age, lost wits, unprofiting actions, empty thoughts". There were sufficient exceptions of this rule to justify a more cheerful view of the passage of time and perhaps this paper may show that the life of men is not divided as Maurice O'Sullivan suggested:—

"Twenty years a growing
Twenty years in blossom.
Twenty years a stooping.
Twenty years declining."

In analysing this series of cases it seemed apt to look at the time spent in hospital prior to death, as shown in Table I.

TABLE I
LENGTH OF STAY IN HOSPITAL PRIOR TO DEATH

Time	No. of Patients
7 days and under	550
7—30 days	605
30—90 days	334
90 days and over	219*
General Practitioner requests ...	5
Total ...	1713

*In this group 21 patients had a total stay of 104 years between them.

Contrary to many preconceived ideas the average hospital time is comparable to that of patients in younger age groups and it is the small "hard core" as shown in this series that makes geriatric units compare unfavourably with turnover figures from an acute unit. The five cases listed under General Practitioner requests were post mortems alone on patients who had died at home where the family doctor wished for further information or a follow-up on cases of known clinical interest.

Major causes of death are shown in Table II and are consistent with findings of Howell and Piggott (1949) and Smith (1950).

TABLE II
MAJOR CAUSES OF DEATH

	Male	Female	Total
Cardio-vascular disease ...	310	233	543
Neoplasm	264	222	486
Bronchopneumonia	83	70	153
Cerebro-vascular disease ...	45	107	152
Acute abdomen	44	58	102
Chronic bronchitis and emphysema	40	24	64
Lobar pneumonia	33	17	50
Genito-urinary	38	13	51
Diabetes	8	30	38
Blood disorders	18	12	30
Tuberculosis	21	10	31
Meningitis	1	3	4
Myxoedema coma	—	3	3
*Miscellaneous	3	3	6
	908	805	1713

*This is made up of the following:—one case each of polyarteritis, adrenal apoplexy, spontaneous pneumothorax, perforated hydronephrosis and two cases of haemorrhage from cirrhosis of liver.

Neoplastic Diseases. When looking at these figures it is of interest to note that lung and bronchial neoplasms head the list whilst McKeown (1965) shows this to be in third place as also did Howell (1958). Four cases of double primary tumours were found, the criterion being that one has two different pathological patterns to be on firm ground for this diagnosis. These cases were (1) carcinoma of prostrate and carcinoma of pancreas; (2) carcinoma of lung and carcinoma of bladder; (3) carcinoma of rectum and sarcoma in neuro-fibromatosis; (4) carcinoma of bronchus and carcinoma of rectum.

TABLE III
*NEOPLASM FOUND IN CURRENT SERIES

Site	Male	Female	Total
Lung and Bronchus	79	20	99
G.I. Tract	26	36	62
Prostate	44	—	44
Pancreas	17	13	30
Liver and Bile Ducts	10	14	24
Breast	—	23	23
Bladder	12	10	22
Uterus and Ovaries	—	16	16
Kidney	6	12	18
Miscellaneous	70	78	148
Total ...	264	222	486

*Four cases of double primaries in this series.

On further analysis it is again confirmed that neoplasms of large intestine are the commonest of those found in the gastro-intestinal tract with preponderance of male rectal carcinoma over that of the female by approximately two to one as shown in Table IV.

TABLE IV
NEOPLASMS OF GASTRO-INTESTINAL TRACT

	Male	Female	Total
Oesophagus	11	8	19
Stomach	26	36	62
S. Intestine	0	1	1
Caecum	3	6	9
Colon	11	25	36
Rectum	19	8	27
	70	84	154

Gastric carcinoma deserves special comment as it is probably the most mis-diagnosed malignant condition, in fact in this series only one in three was correctly diagnosed premortem. In Table V and VI these figures are analysed with brief clinical details which, on the whole, were completely substantiated.

TABLE V
1713 POST MORTEMS IN 70 YEARS AND OVER
62 CASES OF GASTRIC NEOPLASM

	Male	Female	Total	
Diagnosed before death	10	15	25	A.
Clinical carcinomatosis Primary ??	5	3	8	B.
Diagnosed at Post Mortem ...	11	18	29	C.
			62	

TABLE VI
1713 POST MORTEMS IN 70 YEARS AND OVER
62 CASES OF GASTRIC NEOPLASM

Group A
13 cases diagnosed surgically (one was a perforation from Ca. not G.U.).

Group B
Gastric carcinoma suspected in 2 cases, but barium meals, enemas, etc., were negative.
Diagnosis of Carcinoma of head of pancreas in 3 cases.
Acute vascular accidents, 6 Coronary Thrombosis and 1 case of dissecting aneurysm of aorta found to have Carcinoma of Stomach.
Known hiatus hernia, 2 cases found to have Carcinoma of Stomach.
History of Gastric Ulcer (one as long as 40 years), 2 cases of Carcinoma of Stomach.

Group A
3 cases turned out to be Lymphosarcomas not Carcinomas.
1 case diagnosed as Carcinoma histologically was benign fibroma of Stomach (not included in series).

SUMMARY
22 cases out of 62 diagnosed correctly before death.

Before completing this section on neoplastic disease it is of interest to note that amongst the miscellaneous group of 148 neoplasms there were eleven cases of Hodgkin's Disease, 2 male and 9 female, with ages ranging from 90 years to 70 years with an average of 75.7 years. This subject has been briefly dealt with by Howell (1964) and Fullerton (1964), but it is worth reminding clinicians and others that this disease does occur well outside the classically accepted age group.

Acute Intestinal Conditions. These were the precipitating cause of death in 102 cases and because of their clinical importance and the frequency of the "silent abdomen" in elderly patients, the conditions found are laid out in Table VII.

Tuberculosis in the over-seventies is a constant hazard to those in contact with elderly patients and those cases in this series have been dealt with in detail elsewhere, Fullerton (1963).

TABLE VII
ACUTE INTESTINAL CONDITIONS

	Male	Female	Total
Haematemesis			
Duodenal Ulcer	15	4	19
Gastric Ulcer	5	3	8
Cirrhosis	1	—	1
Peritonitis			
Appendicitis	3	3	6
Duodenal Ulcer	6	1	7
Gastric Ulcer	2	7	9
Diverticulitis	3	13	16
Ruptured N.G.	3	7	10
Empyema of Gall Bladder ...	3	2	5
Volvulus	—	1	1
Intestinal Obstruction	3	13	16
Acute Pancreatitis	—	3	3
Acute Necrotising Enterocolitis ...	—	1	1
Totals ...	44	58	102

Conclusions

On looking at the pathological finding in this series, one cannot help being aware of the facts that (a) many conditions occur in geriatric patients which, if diagnosed earlier, are in highly treatable groups, hence saving in hospital beds and (b) the relatively small numbers of patients who can be classified as wholly geriatric.

This over-70 age group is a magnificent source of clinical and diagnostic medicine and often because of lack of friends and relatives welcome visits from undergraduate and post-graduate students (Morton 1966). In fact, in the majority of cases little inconvenience is caused by examination and much can be heard and found, e.g., aortic and mitral stenosis in association with other major pathology, to mention a multiplicity of neurological syndromes.

In view of these figures and my comments, may I ask that as a pathologist I cannot wholeheartedly agree with Shakespeare's sombre view of old age:—

> "Last scene of all. That ends this strange
> eventful history. In second childhood and
> oblivion. Sans teeth, sans eyes, sans everything."

REFERENCES
Howell, T. H., Piggott, A. P. Geriatrics, 1949, **4**, 281.
Geriatrics, 1950, **5**, 90.
Howell, T. H. British Medical Journal, 1964, 1117.
McKeown, F., British Journal. Cancer, **10**, 251.
Pathology of Aged. Butterworth, 1965.
Stewart Smith, G. Lancet, 1950, p. 24.
Fullerton, J. M. British Medical Journal, 1964, 1253.
Fullerton, J. M. and Dyer L. Tubercle, 1956, **46**, 193.

WILLS LIBRARY ANTIQUITIES

2. INDUSTRIAL MEDICINE

By William Hill

The first known work on industrial medicine was written in 1473 by Ulrich Ellenbogut but, for some reason, was not published until 1524. It was an eight page work entitled *Von den gifftigen besen Tempffen und Reuchen.* An English translation was published in the *Lancet* in 1932. This translation was made from the only copy known to exist and from which a facsimile was made in 1927. The contents of the pamphlet are mostly concerned with workers with metals.

The first adequate text on industrial medicine was written by Bernard Ramazzini in 1700 called *De morbis artificum diatriba.* Ramazzini was born in Capri in 1633, studied at Parma and after twelve years in practice became Professor of Medicine at Moderna. He remained there for thirty years and left to become Professor of Medicine at Padua, where he spent another thirteen years.

His interest in occupational medicine was aroused by talking to a labourer cleaning out the cess-pit of his house and learning something of the conditions under which he worked. He became convinced that many occupations were the cause of injury to those engaged upon them and he wrote:—

> "I have done what I could and have not thought it unbecoming to make my way into the lowest workshops and study the mysteries of the mechanic's arts."

He divides the book into sections devoted to separate trades. He covers pneumoconiosis, silicosis in china clay workers, lead poisoning, diseases in metal workers and one of the chapters is devoted to the diseases of learned men! An English translation was published in 1940.

The Wills Library does not possess a copy of the original edition of 1700 but it does have a copy of his collected works which was issued in 1717. This also contains his work on epidemiology which he considered was his best work. No one remembers this but he will always be known by *De mortis artificum*. There is a journal devoted to social hygiene published in Florence and named *Il Ramazzini* in his honour.

The first book on industrial medicine written in England was by Charles Turner Thackrah and called *The effects of the principal arts, trades and professions and of civic states and habits of living on health and longevity*. . . . Thackrah was a Guy's man, born in Yorkshire in 1795 and became a pupil of Sir Astley Cooper in 1815. He was a brilliant student although he suffered from ill-health all his short life. He won a Physical Society prize for an essay on diabetes in 1816. The library has a small collection of these Physical Society essays and among them is one on diabetes but, unfortunately, it is impossible to verify that this is the essay written by Thackrah.

Astley Cooper used to award an annual prize to his students for the best essay on a subject of his choosing. In 1818 the subject was the blood, and Thackrah submitted an essay. Astley Cooper was impressed with it, awarded him the prize, and suggested that it be published. Thackrah rewrote it and it appeared in 1819 as *An Inquiry into the nature and properties of the blood*.

Soon after this Thackrah returned to Yorkshire and settled in Leeds. In 1830 he published the first edition of his book and in the following year reissued a much larger version. He wrote:—

"The object of this paper is to excite the public attention to the subject. Myself and my pupils have personally and carefully inspected the state of the artisans in most kinds of manufacture, examined the agencies believed to be injurious, conversed on the subjects with masters, overlookers, and the more intelligent workmen, and obtained many tables illustrating the characters of the disorders prevalent in the several kinds of employ."

The late Professor Payling Wright, in a paper in the *Gazette*, wrote: "If a man's importance be judged by the influence that he has had upon his own and later generations, Charles Turner Thackrah is the most significant figure that Guy's has yet produced."

Thackrah hoped to issue a second edition of his book on the blood but he died before he could complete it in 1832.

Unfortunately, the library does not possess a copy of the original work but we have a copy of the 1957 reprint prepared by Dr. Andrew Meiklejohn, who also presented us with his original manuscript of the sources he used when preparing the biographical section of the reprint. The library has two copies of the *Inquiry* and one will be on display with the other items mentioned in this note.

QUIZETTE : Orthopaedics

1. Osteoid osteoma is . . .
   (a) A histological finding in healing rickets? (b) Found in relation to fracture callus? (c) A bony swelling in the skull? (d) Painful and relieved by aspirin? (e) A benign bone tumour?
2. Treatment of congenital dislocation of the hip should begin . . .
   (a) When the child is three months old? (b) When the child begins to walk? (c) As soon as the condition is diagnosed? (d) At two years of age? (e) When symptoms occur?
3. Infection following an open fracture of the tibia may be minimised by . . .
   (a) Antibiotics? (b) Adequate wound excision? (c) Secondary suture? (d) Immobilisation in a plaster cast? (e) repeated dressings?
4. Perthé's disease is . . .
   (a) Common in girls? (b) A congenital condition? (c) An idiopathic avascular necrosis of the upper femoral epiphysis? (d) a slipping of the upper femoral epiphysis? (e) Produced by repeated attacks of the bends?
5. Non-union of a fracture is commonly caused by . . .
   (a) Impaction? (b) Comminution? (c) Anaemia? (d) Inadequate immobilisation? (e) Distraction?
6. Multiple osteolytic lesions in the skull are seen in . . .
   (a) Multiple myelomatosis? (b) Eosinophilic granuloma? (c) Metastatic carcinoma of the breast? (d) Osteomalacia? (e) Hydatid disease?
7. Match the following . . .
   (A) Pott's fracture; (B) Pott's disease; (C) Colles' fracture (D) Galleazzi fracture; (E) Monteggia fracture.
   (a) Fracture of the lower end of the radius and ulna; (b) Fracture lower end of radius with subluxation of inferior radio-ulna joint; (c) Fracture dislocation of the ankle; (d) Tuberculous infection of spine with paraplegia; (e) Fracture of ulna with dislocation of head of radius?
8. Which of the following is true . . .
   (a) Rheumatoid arthritis predominantly affects weight-bearing joints? (b) Osteo-arthritis may be localised or generalised? (c) Gout never occurs in females? (d) Ankylosing spondylitis is diagnosed by X-ray of the sacro-iliac joints? (e) Reiter's disease is a non-gonococcal urethritis, conjunctivitis and arthritis.
9. Which of the following malignant tumours commonly metastasize to bone . . .
   (a) Hypernephroma? (b) Carcinoma of the stomach? (c) Malignant Melanoma? (d) Carcinoma of the rectum? (e) Carcinoma of the cervix?
10. A fall on the out-stretched hand may cause which of the following :
    (a) Fractured clavicle? (b) Fracture of scaphoid? (c) Fracture of the head of the radius? (d) Colles' fracture? (e) Fracture upper end of humerus?
11. An ill child with a high temperature complains of pain just above the ankle and is unwilling to take weight on the leg . . . the diagnosis is :
    (a) Rheumatic fever? (b) Osteomyelitis? (c) Acute tonsillitis? (d) Still's disease? (e) Anterior poliomyelitis?
12. Which of the following is true?
    (a) Osgood-Schlatter's disease is self-limiting and heals spontaneously; (b) Scheuermann's disease affects the shoulder; (c) Calve's disease affects the spine; (d) Panner's disease affects the wrist joint; (e) Hoffa's disease produces pain in the infra-patellar region.
13. In hyperparathyroidism, the following bone changes may be seen . . .
    (a) Generalised osteoporosis? (b) Tufting of the terminal phalanges? (c) Osteolytic lesions in long bones? (d) Osteoblastic lesions in the

pelvis? (e) pseudo-fractures?

14. Treatment of a fracture of the upper end of the femur in an elderly patient is . . .

(a) Reduction and traction on a Thomas's splint? (b) Immobilisation in a plaster hip spica? (c) Internal fixation and early mobilisation? (d) Primary replacement with an Austin Moore prosthesis? (e) Liable to be unsuccessful?

QUIZETTE ANSWERS

1. **(d), (e)**
Osteoid Osteoma [1] is a benign bone tumour which presents as a constant dull ache relieved by aspirin. It was first described by Jaffe in 1935. It occurs in the 20-40 age group affecting males twice as commonly as females. It is situated mainly in the long bones and especially around the knee joint, although no bone is exempt. If untreated, it undergoes spontaneous healing within seven to ten years. Treatment is surgical; if removal is incomplete, local recurrence occurs.

Osteoid is incompletely calcified immature bone found in Rickets and uniting fractures.

An osteoma is a bony swelling in the skull. It may be composed of compact or cancellous bone.

2. **(c)**
Treatment should commence as soon as the condition is diagnosed, ideally this should be within the first three weeks after birth The routine examination of the hips of newborn children utilising the Ortolani test was first performed by Rosen [2] in Malmo and Barlow in Salford. Early diagnosis and treatment produces a normal hip. Most hospitals in this country now routinely diagnose C.D.H. in the first few weeks of life.

3. **(b), (d)**
Adequate wound toilet and excision, performed within 4-6 hours of the injury is the only certain way of avoiding infection. All foreign material and dead tissue must be removed. Antibiotics will only sterilise the areas where blood supply is adequate; they cannot penetrate dead tissues. Following adequate wound excision, immobilisation allows the inflammatory reaction to be undisturbed.

4. **(c)**
Perthe's disease [3] is a condition of idiopathic avascular necrosis of the upper femoral epiphysis seen most commonly in boys between 8-14 years of age. It is one of the conditions included in the group of Osteochondritis. It is probably traumatic in origin although there is often a strong family history.

Slipping of the upper femoral epiphysis (Adolescent Coxa Vara) occurs around puberty commonly seen in overweight sexually immature boys and girls.

Avascular necrosis of bone may occur in divers who suffer repeated attacks of the bends. The lesions are most commonly seen in the upper ends of the humerus and femur.

5. **(d), (e)**
Inadequate immobilisation of a fracture is an important cause of delayed or non-union. The movement at the fracture site prevents the organisation of the fracture haematoma so that bridging callus cannot form. Distraction by separating the bone ends also predisposes to non-union.

Impaction occurs when the bone ends are pushed together and in fact aids fracture union.

A fracture is described as being comminuted when many fragments are present. Anaemia plays little or no part in fracture healing.

6. (a), (c)
Multiple osteolytic lesions in the skull are seen in Multiple Myelomatosis and metastatic ca. of the Breast. These two may be differentiated by examination of the urine for Bence Jones protein, and examination of the serum proteins for abnormal globulins. A positive sternal marrow is diagnostic in Myeloma.

Osteomalacia produces a uniformly thinned skull.

Eosinophilic Granuloma and Hydatid disease [4] produce solitary osteolytic lesions. The Casoni test is positive in Hydatid. Biopsy is required to confirm Eosinophilic Granuloma

7. **(A), (c); (B), (d); (C), (a); (D), (b); (E), (e)**
For details of eponyms see 5.

8. **(b), (d), (e)**
Rheumatoid Arthritis [6] is a systemic disease with a strong familial tendency. It affects the small joints of the hands and feet first, occurring in attacks each leaving more permanent joint damage. Large joints may be affected but late in the disease. Osteoarthritis is essentially a disease of large weight bearing joints usually limited to one or two joints e.g. Hip or Knee. There is however a senile generalised form which affects many joints including the hands where Heberden's nodes may be seen. Although gout occurs mainly in males, it is also seen in females.

9. **(a)**
The primary malignant tumours which metastasize to bone are: Thyroid, Lung, Prostate, Breast, Kidney.

10. **All of these**

11. **(b)**
The diagnosis is Acute Osteomyelitis of the Tibia [7]. This may be made in the presence of minimal local signs e.g. tenderness only. The following investigations should be performed, full blood examination including E.S.R., blood cuture, and X-ray. The limb should be immobilised and an appropriate antibiotic e.g. Orbenin commenced. Surgery may be indicated if pus can be demonstrated.

12. **(a), (c), (e)**
Osgood-Schlatter's disease is osteochondritis of the tibial tubercle. It causes pain which is aggravated by exercise, it is self-limiting.

Scheuermann's disease is a pressure epiphysitis affecting the ring epiphysis of the vertebral body.

Calve's disease is collapse of the vertebral body due to Eosinophilic Granuloma.

Panner's disease is an osteochondritis affecting the lower end of the humerus.

Hoffa's disease [8] is a painful disorder of the infra-patellar pad of fat occurring in young women

13. **(a), (b), (c)**
Increased secretion of the parathyroid hormone causes a mobilisation of calcium and phosphorus from bone generally.
Osteoblastic lesions occur from metastatic spread from carcinoma of the prostate. Pseudo-fractures are stress fractures occurring in osteomalacia.

14. **(c), (d), (e)**
All agree that early operation is required if the patient's life is to be saved. Bedrest rapidly leads to pressure sores, chest and urinary infections and death. Smith Petersen described the tri-flanged nail for internal fixation of these fractures. In recent years, primary replacement with an Austin-Moore femoral head prosthesis has been recommended due to the high incidence of non-union and avascular necrosis.

REFERENCES

[1] Jaffé, H. L. (1953). Proc. Roy. Soc. Med., **46,** 1007.
[2] Rosen. S. von (1962). J. Bone Jt. Surg., **44B,** 284.
[3] Evans, D. L. (1958). J. Bone Jt. Surg., **40B,** 168.
[4] Katz, A. M. and Pan, C. (1958). Amer. J. Med., **25,** 759.
[5] Mercer Rang. Anthology of Orthopaedics. E. & S. Livingstone Ltd., 1966.
[6] Capener N. (1950). Modern Trends in Orthopaedics. Ed. Sir H. Platt. London, Butterworth.
[7] W. N. Gilmour (1962). J. Bone Jt. Surg., **44B,** 841.
[8] Hoffa (1904) J.A.M.A, **43,** 795.
[9] R. S. Garden (1964). Journal of Bone and Joint Surgery. **46B,** p. 630.
[10] Austin T. Moore (1957). Journal of Bone and Joint Surgery, **39A,** p. 811.

Compiled by M. A. Nelson.

CRITICISM

THE RECRUITING OFFICER

The Summer Production of the Theatre Club was a considerable success. The choice of play was commendable since George Farquhar's "*The Recruiting Officer*" offers to director and cast alike a challenge which could be easily accepted by the production of a second-rate compromise about which everyone would be very nice and that would be that.

But Russell Cowan is clearly a sophisticated producer who presented us with a stylish version in which pace and crispness delighted ear and eye.

The play is one in which Restoration Comedy enters a larger area of social commentary without moralising. And it also tells us a lot about war and the profession of arms.

The Recruiting Officer, Captain Plume, and his N.C.O. Sgt. Kite descend upon Shrewsbury in search of new men for the regiment. Soon they are embroiled in a complex series of plots which do not really bear close scrutiny, but which carry one along in the wake of a series of beautifully observed characters.

Kite is an outstanding member of a military tradition of crafty venality of which Sergeant Bilko is, I suppose, the modern counterpart. Certainly anyone who has been in the services knows Sgt. Kite and, as I did, must have enjoyed the feeling of instant recognition at his entrance.

Of all the individual performances, David Graham's Kite was undoubtedly the best. His presence was excellent and his timing faultless. Note too that he displayed a professional feeling for his audience which had none of the anxious possessiveness of the gifted amateur. I liked, too, the quiet force of Peter Davenport's Plume which came across with likeable assurance. Brazen (Andrew Seal) was clearly derivative of the National Theatre Original or I am mistaken, but it was none the less extremely popular with the audience and why not?

Tina Cocks' Silvia was the best of the girls and was a memorable example of the high standards that I now expect from the Theatre Club. Jean Morpugo's Rose was a fine piece of sly nubility but Veronica Cumming Bruce seemed bemused by the part of Melinda. But this is carping, however. The whole was an outstanding success.

J.H.W.

CORRESPONDENCE

Dental Auxiliaries

SIR,—Mr. Lambden's article in the *Gazette* of 22nd July about the Dental Auxiliary Experiment will have been of interest to all Dental Surgeons and Students.

As one who has some doubts about the scheme, I would like to put one or two points which Mr. Lambden or your correspondents might comment upon.

(1) What steps have been taken to establish a real differential in the public mind between the Auxiliary and the Dental Surgeon?

To the public a Dentist is someone who "pulls" or "fills" teeth. There is no distinction between treatment of deciduous or permanent teeth. This is of great importance at a time when the profession is seeking to improve its terms and conditions of service. Our case is not strengthened by producing in two years girls who to the public, unless we are very careful, will become indistinguishable from Dental Surgeons. However much we debate, it is public opinion which is the ultimate factor in any argument about conditions of service.

(2) Can anyone predict how many of these girls will stay in the profession? If we assume a 70 per cent marriage rate, the number who will still be working full time in 10 years will not be high. Are we, in the current jargon, getting maximum "cost effectiveness"?

(3) The main problem the profession is trying to solve is shortage of manpower. What is the school leaver and potential undergraduate to think of a profession where girls are trained in two years to the tasks which will occupy a very large amount of *their* time when they graduate. The returns of work done under the National Health Service show that amalgams, silicates and extractions form the vast majority of the work done by the general practitioner.

Auxiliaries are with us. No amount of argument will banish them. I feel they have come at the wrong time and only as a partial answer to one of the profession's problems.

That there is considerable general concern over the question is shown by the fact that the British Dental Journal is refusing advertisements for Auxiliary Apartments until there is satisfaction over the clauses concerning supervision of their work in the final G.D.C. report on the Auxiliary Experiment.

In my opinion the Auxiliary Experiment can only be relevant when the scope of work to be done under the State Health Services by the Dental Surgeon himself has been settled. Only if this is done will all Dental Surgeons accept the Auxiliary without reservation. If no such action is taken, then it is inevitable that there will be concern at the addition of yet another factor to what is already an uneasy equation.

Yours, etc.,

R. C. PATERSON

Dental Department,
Guy's Hospital,
London Bridge, S.E.1.

Guy's Bristol Dinner

SIR,—We would like to thank all those associated with Guy's who supported the dinner in Bristol on the 7th July. The total of fifty-four was a considerable one, and we may perhaps hope that next year two meetings may result, one in Bristol, and one at the annual B.M.A. Meeting, which will be held in Eastbourne in June, 1968.

Yours, etc.,

DR. PHILIP HICKSON, DR. A. T. M. ROBERTS, DR. S. C. C. SCOTT.

Station Road,
Epping, Essex.

NURSING SECTION

Repercussions of "Sans Everything"

Publication of the book " Sans Everything " by Mrs. Barbara Robb some weeks ago created a storm of exclamation, horror and protest in the nursing and medical world, to say nothing of the National press.

This book made a number of allegations of cruelty and malpractice in some of the psychiatric geriatric wards of the hospitals in the National Health Service.

The Nursing Mirror followed up the book's publication with three questions to which it invited its readers to send in their answers. The questions were (1) Would you complain to your superior if you knew of malpractices? (2) If this fails would you go to higher authorities—revealing both your name and your hospital? (3) Do you believe you would survive discredit for your action and really alter the situation?

The dozens of replies to these questions are purported to have shocked Mr. Kenneth Robinson, the Minister of Health. Certainly the majority of the answers to the third question were "No". Mr. Robinson has stated his aim to "uncover and eliminate" any malpractices—together with an unspecified promise of "further action".

Suggestions have been made by various experts, since this statement, for the setting up of independent inquiries or hospital commissions to deal with complaints from both staff and patients alike.

However, the normal Ministry inquiries never lead to any satisfactory conclusion—if ever they can be satisfactorily carried out in these sort of circumstances. Unless the inquiry is there to count the number of days sheets are unchanged on patients' beds, or the number of patients who share the same bath water, there can be no evidence produced or conclusions drawn.

At the Royal College of Nursing Conference in Manchester last week, it was pointed out that the discovery of a few facts in a few unnamed hospitals will not solve the problems of the majority of hospitals in this country, and if remedies are applied under the present system of hospital administration, the situation will remain unchanged.

It will prove impossible to inspect the problems of staff selection, motivation, attitudes and standards of professional efficiency, and unless the whole system of maintenance of standards is drastically altered, we may as well retire back into our cocoons.

If, however, nurses and patients are free and under no threat of reprisals on reporting cruelty or malpractices to their Boards of Governors or Hospital Management Committees, then if these governing bodies honestly carry out their duties and rectify the situations, and are under obligation to forward these allegations to the Ministry accompanied by a report of the steps taken to change the systems, the inquiry could be furthered and the situations remedied.

It is to be hoped that the publication of all that is being discussed and proposed will continue to be published for all and sundry to read, it appears that only in this way can the people concerned be motivated, mainly by shame, to make any effort to change any of the present practices.

Matron's Ball

This year, Matron's Ball was held on the 7th July at the Grosvenor House Hotel, where over 350 from the Guy's Group of Hospitals, plus their escorts, spent a delightful evening.

The guests were greeted in the foyer by Matron and Mr. Richard Hayward, C.B.E., of the Board of Governors of Guy's and St. Olave's Hospitals, and Chairman of the Supplementary Benefits Board of the Ministry of Social Security, before they proceeded to the Ballroom itself.

The music was played by Sidney Lipton and his band, alternating with a spirited Jamaican Steel Band; and provided background for both followers of the Victor Silvester style and devotees of the discoteques.

At 10.30 p.m. a delicious supper, including trout, chicken, and a witty dessert of " Cignes sur le Lac " was served, the whole accompanied by chilled Graves Monopole. Coffee and the " Thin Mints " added the finishing touch to a pleasurable meal.

Dresses this year included the colourful, the amusing, the frankly mod, and the simply elegant—all contributing to the glittering chandeleered grandeur of the Grosvenor House.

The table flowers, beautifully arranged, were by tradition in the blue and gold of Guy's colours, and Matron carried a tasteful bouquet of gold roses bound with blue.

In 1965, at the Matron's Ball held at the Dorchester Hotel, Matron expressed the wish that the Balls thereafter might be bigger and even more splendid, and this wish, I feel, has been gratified, since all the nurses above the status of Head Nurse who wished to attend the Ball, obtained tickets.

I would like to take this opportunity of publicly thanking the Board of Governors for their generosity in the gift of Matron's Ball, and all those who helped to make it such a memorable occasion.

SUSAN M. BALDWIN, S.R.N.,
Secretary to the Nurses' Representative Council.

Miss Edith Doubleday died recently. After her training at Guy's she joined the Nursing Sisters of St. John The Divine, and she became their Mother Superior.

STAFF CHANGES AND APPOINTMENTS

NEW APPOINTMENTS

Sister M. Fairlie (Guy's 1960-64), to Nuffield A. Floor.

Sister B. White (Beckenham Hospital 1942-44, Guy's 1944-47, Ward Sister 1947-61, Admin. Sister 1964-66), to be Assistant Matron in Charge of Allocation.

RE-APPOINTMENTS

S/N J. Harebottle (Grotte Schurr Hospital, Cape Town), to Nuffield D. Floor.

S/N A. J. Head (Addingtons Hospital, S. Africa), to Barnabas Ward.

RESIGNATIONS

Sister J. Bennett, from Admin. Matron in Charge of Allocation to Deputy Matron, Royal Victoria Hospital, Bournemouth.

S/N K. Bunny, from Nuffield A. Floor.

S/N A. Iverson, from Diplock Ward.

S/N H. Mackie, from Diplock Night Duty.

S/N S. J. Moody, from Theatres.

S/N A. M. Orchard, from Barnabas Ward.

S/N G. Threlfall, from Bright Ward.

S/N E. O. Robertson, from Recovery, Main Theatres.

S/N H. M. Ward, from York Clinic.

S/N J. M. Welch, from Christoper Ward.

S/N A. M. Williams, from Main Theatres.

---

90 Years Ago

From a Patient's Journal. August, 1877.

Then comes the dressers and reporters to attend to the patients who require their services, and then the house-surgeon comes round the ward, enquiring carefully after the health and condition of each patient, giving each a word of encouragement and, as he leaves you, you feel a kind and sympathising friend has left you . . . . and the last thing at night, round comes the house-surgeon with so silent a step and so noiseless a footfall that patients often express their surprise to learn that he has passed.

50 Years Ago

August, 1917.

From a paper on Psycho-Analysis and War Neurosis by Dr. Arthur F. Hurst.

The mental attitude of the psycho-analyst is well shown in a paper on " Functional Nerve Diseases and the Shock of Battle " by David Forsyth, who states that " the neurasthenia of civil practice is known to be the specific result of excessive onanism "! He proceeds to describe two cases of exhaustion following the stress and strain of active service, one of which his analysis showed was due to " unconscious homosextuality " combined with " anal eroticism, which has played a leading part in the patient's psychical life since an attack of diarrhoea in childhood ".

REVIEWS

A SHORT TEXTBOOK OF SURGERY.

Selwyn Taylor, who is the general editor of the University Medical Texts, has somehow found time, together with Cotton and Professor Murray at King's College Hospital to publish a welcome edition to a series of paper-back short textbooks. For 30s. the purchaser receives approximately 600 pages of text covering the whole of surgery. Obviously such coverage is superficial as it must be in any single text-book attempting to contain so large a subject. Even so, I was surprised to find how much can be included in a book this size. This has been achieved by certain economy of words in the text without resorting to a series of lists so difficult to read and to remember. The text is very clearly laid out and a pleasure to read. By resisting the temptation to bespatter the pages with coloured pictures and X-rays collected over years of clinical practice, a further economy of space, and price, has been achieved. Essential illustrations consist of very clear line-drawings. The latter, occasional simple diagrams, an excellent text and finally a few essential, modern, references at the end of every chapter have achieved what I thought was almost impossible—an up-to-date comprehensive undergraduate text-book which can be carried and read in comfort, for less than the price of a good L.P.

J. D. MAYNARD

PHYSIOTHERAPY IN SOME SURGICAL CONDITIONS (3rd ed:)

Joan E. Cash, B.A., M.C.S.P.(T.), F.C.S.P. (Hon). Faber & Faber 1966—pp. 480 illust. *Price* 35*s*.

This book needs no introduction to physiotherapists, having become, since first published in 1955, a standard text-book for students. The 3rd edition, however, has been extensively revised, and contains much new material and new illustrations—in all 33 photographs and 48 drawings. Whereas previous editions were largely written by Miss Cash herself, here other physiotherapists have contributed chapters on their speciality, with inclusion of much background information as well as clear, concise accounts of physical treatment.

There are now sections on Thoracic surgery and neurology, which are of particular value in view of the rapid advances made in these fields. Both are introduced by revision of the relevant anatomy and physiology, and in the neurology section there is a resumé of the functions of different areas of the C.N.S. and the effects of lesions at specific levels. Special investigations are outlined, and the role of the several members of the team is briefly discussed before the physiotherapy is described.

The chapter on cardiac surgery emphasises the vital nature of co-operation and gives a useful survey of variations in treatment at 14 hospitals other than the author's. A section is given to respirators, drainage tubes and tracheostomies.

The early chapters dealing with wounds and local infections appear to have been less thoroughly brought up to date. Thus histamine ionisation for scarring is mentioned, and the short-wave diathermy technique advocated for superficial infection would not be generally accepted.

Over one-third of the book deals with specific injuries of bone, joint and soft-tissue outlining the surgical procedures which may be adopted as well as the physical means employed in their management. This section is introduced by an account of tissue repair, the complications of injury, and the principles underlying treatment.

The book is well laid out and illustrated, has a good index, and will continue to be a reference book for physiotherapists. Because of the wide range of subjects covered, however, great depth is not possible and students preparing for their Intermediate and Final examinations must refer to more detailed works to supplement their reading.

SPORT

SINGLE WICKET COMPETITION

Being held for the first time, this competition was conducted in an entertaining atmosphere of rivalry which produced moments of unforgettable vitalism. "The Cricket Club Committee" decided that the competition would take the form of four eight ball overs for each player and that the highest score in each game would win. In the event of a draw, then the most runs scored in the least number of balls would decide the winner. The draw allowed for all but four players to have byes in the first round. The Committee further imposed a small financial penalty for each dropped catch.

After consistently good performances in the qualifying rounds, we were not surprised to find Bob Clark and Mike Appleby in the final. Bob Clark had exhibited his skill by scoring 54 not out against Joe Butchey in the semi-final—an innings in which he hit the only six of the competition. However, Butchey had himself miraculously emerged victor from his quarter final game with Silk.

Silk needing only four runs (having bowled Butchey in five balls for only three runs), approached the wicket content to score a single boundary, but alas was caught for a duck in the first over!

Appleby on his way to the final, played Fordham, Beacham, and in the semi-final Davies. This was a commendable performance by Willy Davies to reach this stage by beating Thomson and then Swift. However, he was dismissed by Appleby in the first over for two runs, and Appleby replied by hitting a four off the first ball.

For the final, Bob Clark looked eminently favourite with higher scores than Appleby in his previous rounds, and despite having played one round more than Appleby, he had remained not out throughout the competition; Appleby, however, had been caught in his first round. Both players had dismissed all their opponents. Bob Clark, in fact, seemed in grand form by hitting a four off his first ball. However, on the fourth ball he was brilliantly caught by Davies, taking a skier at deep mid-on.

To win the Final, Appleby replied with 11 not out.

Results

1ST ROUND.

R. Clark, 4 n.o.—P. Williams, 3.
Thomas, 33—R. Carruthers, 7.

2ND ROUND.

R. Clark, 11 n.o.—C. Neville, 10.
A. Gillham, 30 n.o.—R. Kendrick, 29.
Jones, 22— **J. Butchey, 26 n.o.**
B. Rowlands, 7—**D. Silk, 8 n.o.**
M. Appleby, 14—Fordham, 2.
N. Turfitt, 13—**R. Beacham, 14 n.o.**
W. Davies, 13 n.o.—A. Thomson, 12.
P. Swift, 44—Thomas, 29.

QUARTER-FINAL.

R. Clark, 22 n.o.—A. Gillham, 21.
J. Butchey, 3—D. Silk, 0.
M. Appleby, 16 n.o.—R. Beacham, 15.
W. Davies, 10 n.o.—P. Swift, 9.

SEMI-FINAL.

R. Clark, 54 n.o.—J. Butchey 8.
M. Appleby, 4 n.o.—W. Davies, 2.

FINAL.

R. Clark, 7—**M. Appleby, 11 n.o.**

CRICKET RESUME

Recently, Guy's cricket has been dominated by a return to form of Joe Butchey, and also less favourably by poor fielding. Against a weakened Nomads' XI, although winning by 50 runs, this game could have been brought to an earlier victory had the fielding been improved.

Alas the poor fielding against Streatham allowed their opponents to declare at 222 for 5, and with only 145 minutes to play, Guy's really did not seem able to win, even though Joe Butchey scored 79, Brian Rowlands 31 not out, and Bob Clark 33.

The weather was the deciding factor against a strong Metropolitan Police XI. Having lost the toss, Guy's were surprised to find themselves batting first on a seemingly good batting wicket—but runs came slowly and they eventually declared at 150 for 6 with Joe Butchey 61 not out. Dropped catches helped the Police to push their score along quite quickly. However, rain postponed play temporarily, and Guy's were afterwards unlucky to find the wicket even less responsive and eventually lost by 4 wickets.

The 4th August heralds the start of the Cricket Club Tour. In order to accommodate two new fixtures against Hayling Island and Chichester Priory, the Tour has been extended by a day. It is hoped that Guy's men will support these games wherever possible.

DIARY

CRICKET—TOUR

Aug. 4.—Basingstoke, 2.30 p.m. A.
,, 5.—Hayling Island, 2.0 p.m. A.
,, 6.—Bognor, 11.30 a.m. A.
,, 7.—Ferring, 2.30 p.m. A.
,, 10.—Cuckfield, 11.30 a.m. A.
,, 11.—Chichester Priory, 11.30 a.m. A.

CRICKET

GUY'S v. U.C.S. OLD BOYS

At H.O.P. Saturday, 8th July, 1967

Result: lost by 8 wickets

Guy's, 108. (Chase, 53; Appleby, 24.)
U.C.S.O.B., 109 for 2. (Beacham, 2 for 19.)

Having won this game last year by eight wickets, we started the day full of confidence despite the fact that we were put in to bat. However, to our great horror, we soon realised that the wicket was playing very badly and that due probably to some overnight rain, the ball was bouncing irregularly and dangerously.

Under these circumstances, our batsmen struggled, but some were unfortunately out to almost unplayable deliveries. Chase and Appleby batted quite well, and Chase in particular fully deserved his score of 53, which he got only after several assaults on his body. By the end of our innings, however, the moisture had dried out and the wicket was starting to play much better.

When U.C.S.O.B. went in to bat, our bowlers did not get so much help out of the wicket as the opposition and they were able to revenge and at the same time reverse the decision of one year ago. Beacham was our successful bowler of the day.

J. R. K. BUTCHEY

GUY'S v. THE NOMADS

At H.O.P. Saturday, 15th July, 1967

Result: Guy's won by 50 runs

Butchey and Gillham opened the innings for Guy's against a somewhat depleted Nomads team. Though Gillham was soon caught at the wicket, Butchey and Clark batted confidently. After this partnership had been broken, there followed some most undistinguished batting by the middle order.

With the score of 77 for 7, Rowlands joined Davies, and both proceeded to bat sensibly and steer Guy's out of a drastic situation. When they had put on 68, and were really beginning to master the bowling, both were out; Davies having first reached a most meritorious maiden half-century. The innings closed at 160, with Beacham, who had at long last demonstrated the power of his hitting, left stranded without any partners.

With one or two exceptions, the Nomads' batsmen hardly looked capable of scoring many runs, let alone compiling 160. The attack was left mainly in the hands of Clark and Pearson, and both responded by bowling steadily, which turned out to be enough to dismiss the Nomads for 110.

Scores

Guy's, 160. (Davies, 58.) (Boyer, 6 for 48.)
Nomads, 110. (Ellison, 42.) (Clark, 6 for 29; Pearson, 3 for 47.)

M. I. APPLEBY

GUY'S v. STREATHAM

At H.O.P. Sunday, 16th July, 1967

Result: drawn

Streatham had first use of a good batting wicket, and took full advantage to amass a total of 222 for 5 declared. This might indicate that the batsmen dominated the bowlers, but this was not so. That they made such a score was helped by two factors—luck, and a poor display in the field by Guy's. Clark was the most successful bowler, and Beacham the unluckiest. One bright spot in this drab fielding display was a remarkable one-handed diving catch by Beacham in the covers.

Chasing this formidable total in 145 minutes, Guy's were given their best start of the season by Butchey and Clark who put on 72 in less than an hour. Clark was eventually well caught in the slips; when Chase was next out, the required run-rate had risen to 140 in 70 minutes. In spite of valiant attempts by Butchey, who made 79 very good runs, Rowlands and Pearson, Guy's could never catch up with the clock and finished 28 runs short.

Scores

Streatham, 222 for 5 declared. (Etheridge, 64; Hayward, 64.) (Clarke, 3 for 52.)
Guy's, 194 for 7. (Butchey, 79; Clark, 33; Rowlands, 31 not out.)

M. I. APPLEBY

GUY'S v. METROPOLITAN POLICE

Result: lost by 4 wickets

Guy's, 150 for 6 dec. (J. Butchey, 61 not out; R. Clark, 29.)
Metropolitan Police, 151 for 6. (J. Reeve, 62 not out.) (S. Davoodbhop, 3 for 32.)

It was sports day at Imber Court with sideshows, athletics, a brass-band and a cricket match. The latter was an interesting game in which Guy's were beaten by a very comfident Police side.

The toss was lost and Guy's were asked to bat on what appeared to be a good, batting wicket. Characteristically, our start was slow, the opening bowlers were brisk, and Thomson was soon out. Butchey was joined by Clark and the scoring rate increased a little. The latter drove anything that was pitched up to him and Butchey was exhibiting all his Caribbean flair and some of his shots were hardly credible.

The cricket was interesting at this point and eyes were diverted for a time from the many and assorted races that were held on the adjoining track. Clark was out after he had scored a good 29 runs, but Guy's were still behind the clock. The remaining batsmen were out trying to force the pace on a wicket that began to take an increasing amount of spin. Swift's brief innings was entertaining, if a shade unorthodox, and he has promised to show us all how to play the one that goes for four over the wicketkeeper's head. At tea Guy's declared sportingly with Butchey 61 not out.

After the interval, the Guy's attack was opened by D. Crafts and Davoodbhoy, the latter adopting the unusual role because it was thought, justifiably, that the wicket would take a considerable amount of spin. Our bowlers got little assistance from the pitch, however, and the first wicket was captured only after the regular opening bowler was re-instated. After a few more wickets had fallen quickly, J. Reeve was brought to the crease. This excellent batsman scored a very quick, chanceless century against us last year in the corresponding match, and not unexpectedly from this moment the scoring rate increased.

The old Guy's "bugbear", dropped catches, helped the Police batsmen in their efforts to acquire the necessary runs; this time the fault came from an unexpected quarter.

Rain began to fall at this stage and play was stopped for a short time—this, we thought, would help us to "save" the game. Unfortunately, the rain had deadened the wicket and the bowlers found the wet ball very difficult to hold. Reeve found the conditions and the bowling to his liking and the remaining runs were obtained at a fast rate by some very competent and aggressive batting.

We left the field a defeated side, but unfortunately the band had gone and therefore were not able to help us overcome our depression!

R. J. BEACHAM

THE LAWN TENNIS CLUB

This season has proved disappointing in many respects. The strength of the first VI has been depleted on many occasions, since the aura of exams has hung over many of the team members. A. Quant, a qualified dentist, who has now returned to Guy's to do a medical degree, has proved a valuable asset to the team.

The early weeks of the season were marred by bad weather, which resulted in the cancellation of many matches. Our first victory of the season was gained against the Royal Naval College, Greenwich, who entertained us to an excellent dinner, when the tennis had finished.

In the Hospitals' Cup, we were fortunate in obtaining a bye through to the semi-final, the Royal Free Hospital having scratched from the competition. In the semi-final, we overwhelmed St. Bart's by the convincing margin of eight matches to one. The Final, against the Middlesex Hospital, was played on the 18th July at Chislehurst. J. Newman and A. Quant, playing first pair, won their three matches fairly convincingly. However, our third pair, R. Hughes and J. Anderson lost both the matches they played. The second pair, P. Swiss and R. Machell, defeated the Middlesex second pair after a few setbacks and finally defeated the opposing first pair 13—15, 6—4, 7—5 after a titanic struggle! The match was thus won by the margin of 5—2, with two matches unplayed, and the Hospitals' Cup retained for the third year in succession.

The season ended on rather a sad note, when the Hampshire weekend had to be cancelled through lack of support. It is to be hoped that this apathy will be replaced by fresh enthusiasm next season.

R.J.M.

UNITED HOSPITALS' SWIMMING GALA, 1967

In the recent United Hospitals Swimming Championships of 1967, which were held at the Shell-building pool, Guy's men's team improved on their position last year by achieving runner-up position to the London Hospital. This was achieved without a single first place, which though in itself is hardly commendable, shows complete effort by the club as a whole. Roddy Jones was unfortunately not able to be present since he was representing Great Britain in Rome at the time.

The women's team achieved a magnificent hat-trick, coming first for the third consecutive year, although sharing the title this year. Full credit must go to the captain, Miss Jane Abels, for the encouragement she has given to her team which made this possible.

S. CHALLACOMBE

Individual places:
Men

440 yds. freestyle—D. Anderson, 3rd.
110 yds. backstroke—G. Northcott, 4th; D. Davidson, 5th.

110 yds. freestyle—S. Challacombe, 3rd; P. Ashford, 5th.

110 yds. breaststroke—K. Howard, 5th.
Diving—D. Aspin, 2nd
Medley relay—Guy's, 3rd.
Freestyle relay—Guy's, 3rd.
Overall result—Guy's 2nd

Women

50 yds. freestyle—S. May, 2nd.
50 yds. backstroke—S. May, 1st.
50 yds. breaststroke—R. Lennon, 2nd.
Diving, J. Higgs, 1st; S. May, 2nd.
Freestyle relay—Disqualified.
Overall result—Guy's 1st.

HOSPITAL INFORMATION

APPOINTMENTS VACANT

GUY'S HOSPITAL, S.E.1.

Applications are invited for the post of **Senior Registrar in Anaesthetics** for a period of one year from 1st October, 1967. Forms of application are obtainable from the Superintendent, Guy's Hospital, and should be returned not later than **14th August, 1967.**

GUY'S HOSPITAL, S.E.1.

Applications are invited for the post of **Registrar in Ophthalmology** (six sessions per week) to start as soon as possible, with appointment until 30th September, 1968, in the first instance. Forms of application are obtainable from the Superintendent, Guy's Hospital, and should be returned not later than **25th August, 1967.**

GUY'S-MAUDSLEY NEUROSURGICAL UNIT

Applications are invited for the post of **Registrar** (Middle Grade) for one year commencing as soon as possible. The Unit, which is housed in the Maudsley Hospital, serves both Guy's Hospital and the Bethlem Royal Hospital and Maudsley Hospital. Applications should be made by the 26th August, 1967, to L. H. W. Paine, House Governor and Secretary, Maudsley Hospital, Denmark Hill, London, S.E.5.

PASS LISTS

UNIVERSITY OF LONDON

M.D.
Henry Hunter
D.P.H.
M. V. Smith

UNIVERSITY OF CAMBRIDGE

Pharmacology

C. G. Barber — C. R. A. Clarke
T. E. C. Bishop

Final M.B.

Part 1. Pathology and Pharmacology
P. D. Wallace

Part 2. Principles and Practice of Physic

K. G. E. Brown — A. B. Loach
E. P. Davis — B. W. R. Moore
P. D. M. Ellis — J. H. Newman
M. G. Falcon — D. J. Peters
M. J. B. Farebrother — J. G. Pickering
H. Garmany — D. E. P. Shapland
J. J. Halliday — G. H. Warrick
B. D. W. Harrison — N. M. White
R. A. C. Hughes

Part 2. Principles and Practice of Surgery

A. B. Bevan-Jones — R. A. C. Hughes
K. G. E. Brown — J. F. Macfarlane
E. P. Davis — B. W. R. Moore
P. D. M. Ellis — J. H. Newman
M. G. Falcon — D. J. Peters
M. J. B. Farebrother — J. G. Pickering
J. J. Halliday — D. E. P. Shapland
B. D. W. Harrison — N. M. White

Part 2. Obstetrics and Gynaecology

K. C. E. Brown — R. A. C. Hughes
E. P. Davis — A. B. Loach
P. D. M. Ellis — B. W. R. Moore
M. G. Falcon — J. H. Newman
M. J. B. Farebrother — D. J. Peters
H. Garmany — J. G. Pickering
J. J. Halliday — D. E. P. Shapland
B. D. W. Harrison — N. M. White

UNIVERSITY OF OXFORD

Pharmacology and Principles of Therapeutics
R. J. Jacoby
General Pathology and Bacteriology
E. J. Will
Medicine, Surgery and Midwifery
S. R. C. J. Stanley-Little
Surgery
R. A. Oxlade

UNIVERSITY OF LONDON

Ph.D.
R. O. Weller

THE CHARTERED SOCIETY OF PHYSIOTHERAPY

Interim Finals, July, 1967

Durand, V. J. — Lennon, R. A.
Harrington, G. P. — Phillips, J. E.
Ide, L. J. — Speakman, P. A.
Lake, C. M. — White, C A

PERSONAL

FOR SALE—Modern, semi-det. house, 3 bed., 2 recep., good-sized garden. Quiet road near station (Guy's half an hour door-to-door). £5,950 o.n.o. Phone Orpington 23978 or contact Dr. Latham, Department of Physical Medicine.

GUY'S MAN—Seeks an Assistant for West End Dental Practice. Telephone WELbeck 9433, or Box No. 7/2

GUY'S GRADUATE requires small furnished flat October 1967 until March 1968. Central London or Guy's area preferred. A. M. Worth, Poplar Farm, Fen Road, Dunston, Near Lincoln.

GUY'S S.R.N., Graduate, social worker, 30's, wishes to work in various countries en route New Zealand from October. Driver, typist, writer, photographer. Write: Miss Jean Woodger, 11, Etert Street, Abingdon, Berks.

ORPINGTON—20 minutes London Bridge—detached house in quiet cul-de-sac, convenient shops, schools, buses—4 bedrooms, large secluded garden, terrace, summer-house. fitted kitchen, central heating, garage, £9,000 o.n.o freehold. Tel. Farnborough 51896 or Box No. 8/1.

CHANGES OF ADDRESS

B. A. O. Binns, M.R.C.O.G., M.B., B.S., 762a, Commissioners Road East, London, Ontario, Canada.

Dr. J. C. Burt, Associate Medical Clinic, 201-206, Medical Building, Prince Albert, Saskatchewan, Canada.

Dr. K. R. J. Coates, 61, Moreton Hall, 253, North Ridge Road, Durban, Natal, S. Africa.

Drs. Peter and Jean Firth, 12, Dudley Road, Wimbledon, London, S.W.19. Tel. 540 7075.

Mr. and Mrs. A. Winskill, The Flat, 12, Sydney Road, Hayward's Heath, Sussex. Tel. Hayward's Heath 4114.

DEATHS

HODGKINSON—On June 2nd, 1967, Robert John Hodgkinson, M.R.C.S., L.R.C.P.

NESER—On January 25th, 1967, Eric Eugene Neser, M.B., B.S., of Klerksdorp, Transvaal, South Africa.

REINHOLD—On 22nd July, 1967, Colonel Carl Henry Reinhold, M.C., F.R.C.S.(Ed.), I.M.S. (Retd.), aged 86 years

BIRTH

WONHAM—On July 27th, 1967, to Margaret (née Smith) and David Wonham, at Guy's, a daughter, Amanda Jane, a sister for Juliet.

MARRIAGE

CLARKSON—BOWMAN — Gerald William Wensley Clarkson, M.A.(Oxon.), elder son of Patrick Wensley Clarkson, M.B.E., M.B., B.S., F.R.C.S., of 107, Harley Street, W.1, and of Mrs. E. B. Clarkson, of 80, Onslow Gardens, S.W.7, grandson of N. Mutch, M.D., F.R.C.P., Emeritus Physician to Guy's, and great grandson of Sir William Arbuthnot Lane, Bart, C.B., M.S., F.R.C.S., Emeritus Surgeon to Guy's, to Rachel, daughter of Sir John Bowman, Bart., and the late Lady Bowman, and great great granddaughter of Sir William Bowman, F.R.C.S., Emeritus Ophthalmic Surgeon to U.C.H., at Newbury, Berkshire, on Saturday, 8th July, 1967.

ERRATUM

8th July, 1967

"American Elective", by Andrei Calin, p. 358 read "in-bred hospitals" not "ill-bred hospitals".

We would like to remind our readers that all copy for inclusion in the Gazette must be received eight days before the publication date.

Personal notices one shilling per word (Minimum £1. 1s. 0d.)
Birth, Marriage, Death and Change of Address notices are without charge to subscribers.
Non-subscribers will pay £1. 1s. 0d. for all notices other than Personal.

GUY'S HOSPITAL GAZETTE

EDITORS D. S. ROBINS and C. B. BROWN
SPORTS CORRESPONDENT J. G. PAYNE
NURSING CORRESPONDENT E. A. MALPAS

FORTNIGHTLY TWO SHILLINGS VOLUME 81 NUMBER 2063

The opinions expressed in these columns are solely those of their authors and are not to be taken as the views of the Hospital as a whole.

PASSIM

A Dirty Word

It's been quite a summer. As when all governments begin to invert into their incestuous party political entanglements lulled by the prospect of a good few years in further power, so much real progress is left to the individual conscience and effort. Result—private members' bills put through two pieces of legislation which will have a direct effect on the life of many members, be they a minority, of society: an effect of infinitely more consequence than countless pieces of administrative legislation attempting to improve upon earlier countless pieces of administrative legislation.

The medical profession's rôle in the debates on Abortion and Homosexuality has been far from impressive. Disjointed, in one case it allowed a few loud but biased voices to shout down "facts" to an ignorant public, facts that their dispensers would have that these had Galenical powers. In another it kept an almost embarrassing (or was it embarrassed?) silence. Where sound medical knowledge could have saved acres of worthless paper in Hansard its possessors concentrated their words in late-night television discussion, letters to the press and talks to select women's societies.

There is still rampant a falacious belief that the doctor must not involve himself in politics, that politics is a dirty fungus that may bring multifarious diseases upon his patients by tainting the physician's hands as well as his mind. Or even that his medicine may suddenly all be dispensed uniformly red or blue. The myth is that if the doctor has thoughts and opinions of his own it will harm his treatment of those who hold different thoughts and opinions. The pathetic side of this attitude is, then, the frustrated fervour with which the profession privately admonishes the "political interference" in its realm. This continuing refusal to meet a considered enemy in open battle or even to take the fight to the enemy's camp itself is a pervading strategem that would be rightly scoffed at by any campaigner worth his salt. Quite apart from the obvious home ground of the National

Health Service and its alternatives there are many other fields where the medical voice, especially with its psychological accent, could well be heard more effectively. Public health is perhaps equally obvious, but what about other social problems such as warfare, specifically germ and chemical warfare, prisons, driving, schooling, drug addiction and the whole field of stimulants, to name but a few?

The profession is nominally represented by its largest club, the B.M.A., which at its best is the voice of a few politically orientated doctors. Whenever a social problem nears its publicity zenith the old man crawls out of his Tavistock Square four-poster, mumbles under his B.M.J. beard, has breakfast with his conscience and then settles down again for a catnap that is anything but. That a representative is one who must occasionally go out to those he represents is something the comfortable memory has managed to let slip, so that when it finds itself without a considered opinion it has forgotten the technique asking for leadership from those it professes to lead. The debate on abortion was a typical example: the medical profession's opinion in the public eye and ear was almost overwhelmingly that from one area of the country renowned for its opposition to the idea. The true collective voice was so lacking that in the final stages of the bills' progression through the House of Commons, hearing nothing worthwhile from the B.M.A., a reasonable plea for such a voice in the form of a Royal Commission was made. A Commission could do little more than the B.M.A. might have or should have done, viz.. called a referendum with a carefully worded questionnaire to all its member medical practitioners, and have analyzed and compounded the results with well-researched and expert opinion. For months the debate raged in full view of the public, yet not once did the considered political voice of the profession most intimately connected with it rear its head outside of committee reports, and then assail the public and Parliamentary ear unceasingly.

How much longer are we to suffer from the outmoded "no politics for physicians" stranglehold? The medical profession cannot go on dabbling in politics only when the curtains are tightly drawn. It is concerned in its most composite definition in not only the cure and prevention of disease but in the maintenance and propagation of good health. It is concerned with the life of Man, and the lifeblood of that phenomenon is politics.

Mr. Nils Eckhoff

This week saw the retirement of Mr. Eckhoff from the Surgical Staff of the Hospital. In this issue we print an Appreciation of him and also publish the substance of his final Clinical Lecture, "What is Plastic Surgery?" On behalf of all the Guy's family we wish him a most enjoyable and fulfilling retirement, and also wish his successor, Mr. John Maynard, every success in the future.

The Disabled

"Britain," according to Professor Townsend, "has what amounts to an elaborate system of discrimination against the disabled." This conclusion was drawn from evidence taken from a sample survey of 200 people registered as physically handicapped in London, Essex and Middlesex. But it could apply to at last three per cent of the population of this country.

All but a fifth of the sample were middle-aged or elderly, many living alone or spending the greater part of the day on their own while relatives were at work. Interviews with them revealed a huge, latent demand for community services from home helps to meals on wheels, which are simply not being met. But it isn't just a question of services. The disabled, Professor Townsend states, tend to be poorly housed compared with the rest of the community. While just under a half of the sample had simple adaptations made to their houses, the catalogue of inadequacy with regard to basic facilities is pretty appalling. Nearly a quarter of the homes have no bath or lavatory.

Local authorities have been slow to use their powers to operate home working schemes which would be welcomed by many of the housebound disabled. Present schemes tend to be privately run and often came dangerously close to exploitation, with wage rates averaging 3s. an hour. Those who are able to work outside fare little better; 50 per cent of British firms do not take up their 3 per cent quota of disabled workers.

The survey in addition supports the findings collected by the Disablement Income Group on low incomes and injustice in the allocation of social security benefits. Two-thirds of the disabled households had incomes under £10 a week.

A good reason for these poor conditions is the chaotic structure of governmental services for the disabled. No fewer than seven different Ministries are involved with rehabilitation. The Ministry of Health, the Disabled Pensions Section of the Ministry of Labour, the Department of Science and Education (dealing with further education for the disabled and long-term sick), and the Ministry of Social Security all play major roles. But the Ministries of Housing and Local Government, Public Building and Works, and of Transport are also involved.

In addition, another three major bodies (non-governmental) are concerned with all disabilities: the British Council for Rehabilitation of the Disabled, the Central Council for the Disabled and the National Fund for Research into Poliomyelitis and Other Crippling Diseases. This administrative and financial dissipation makes a case for a unified service obvious.

On pensions, Townsend, like DIG comes out firmly in favour of a disability pension based on functional limitation of capacity rather than on source of disablement or loss of earnings. A reasonable rate, he suggests, might be 30 per cent of average earnings (about £6) plus dependency benefits.

But this problem, like many others such as family poverty, housing, town planning, and social security are being solved at a slower pace and without the imagination many hoped for when the present government first declared its mandate on coming to power. Promises have not been kept and many commitments still remain commitments.

Professor Martin Rushton

On July 27th, Mr. David Bruce, the United States Ambassador in London, presented the Elmer S. Best Memorial Award to Professor Martin Rushton, whose contributions to dentistry he described as "outstanding and of world renown". The award was established in 1961 by the Pierre Fouchard Academy of Cleveland, Ohio, in memory of its founder.

Professor Rushton was educated at Cambridge University and here at Guy's, graduating in science, dentistry and medicine. From 1959 to 1962 he was dean of the faculty of dental surgery at the Royal College of Surgeons of England, and was Professor of Dental Medicine at Guy's Hospital Dental School until his retirement in 1966. The *Gazette* published an Appreciation in the issue of 17th September, 1966.

We would also like to congratulate him on being elected as an Honorary Fellow of the Royal Society of Medicine.

GUY'S DIARY

We offer our warmest congratulations to the following on their appointments to Guy's Hospital :—

Dr. Stewart Cameron—Consultant Physician in Renal Medicine.

Dr. Ross Watkin—Consultant Anaesthetist.

Dr. J. Willis—Consultant Psychiatrist for the new treatment centres for Drug Addiction.

We offer our congratulations to Mr. D. J. Neill, Head of the Department of Prosthetic Dentistry, upon whom the title of Reader in Dental Prosthetics has recently been conferred by the University of London.

Also to Mr. A. H. R. Rowe, who has been appointed to the position of Reader in Conservative Dental Surgery in the University of London and Head of the Department of Conservative Dental Surgery, with effect from 1st October, 1967.

An Appreciation

MR. NILS L. ECKHOFF, M.S., F.R.C.S.

The passing of the warm summer brings with it the sad realisation of the retirement this month of our Senior Surgeon, Nils Eckhoff. A direct association with Guy's Hospital and its School for nearly fifty years represents a vast number of acquaintances and few can have gained more friends than this genial and kindly man. For Nils has a friendly and generous personality which will be much missed around Guy's. His patients will remember him for the skill of his surgery and his interest in their welfare; his students, past and present, for the directness of his teaching and his conscientious regularity; his house-

men and registrars for the soundness of his advice and the presence of his support in times of difficulty; and his colleagues for his specialised help and advice often asked and freely given.

Born of Norwegian stock, Nils was educated in South Africa at Durban High School and Natal University, coming to Guy's with a Senior Science Scholarship in 1920 and qualifying M.R.C.S., L.R.C.P. at the age of 21 years. There followed the full sequence of surgical house appointments at Guy's which he completed in November 1924, and it was now apparent that surgery was to be his abiding interest. He set to work with great industry and application to pass the Primary and Final Examination for the F.R.C.S. of England by December 1925, but he was to wait nearly two years until he had reached the age of 25 years before he could formally be admitted to the Fellowship. Appointed Surgical Registrar, a post he was to hold for five years, he realised the most sought-after posts in Surgery at Teaching Hospitals were open only to those with a higher university degree in addition to the F.R.C.S. So with great determination whilst working whole time as a Surgical Registrar, he sat and passed all the examinations for the M.B.B.S. degree of the University of London, obtaining Honours in Surgery in the process! and one year later he had obtained the coveted Master of Surgery degree. After a period as full-time Demonstrator of Anatomy, whilst awaiting a consultant appointment, he was invited by the Governors to the post of Assistant Surgeon in 1933. A naturally neat and dexterous operator he was meticulously careful in whatever he did and it was not unexpected therefore that his interests should turn to the newly-developing art of plastic surgery and in the fullness of time he was granted the title of Plastic Surgeon to the Hospital.

When war came he was enrolled in the Emergency Medical Service and worked throughout at East Grinstead, as plastic surgeon to the Queen Victoria Hospital and General surgeon to the Cottage Hospital, appointments he retained for a number of years in peacetime.

A member of several medical societies, he gave his chief support to the Chelsea Medical Society and the Medical Society of London, both of which honoured him by electing him their President.

Apart from his professional prowess, generations of students will remember the great interest he took in their recreational activities as Treasurer of the Clubs' Union, a post he was invited to resign a year ago so that he could be elected President during his last year at Guy's. They will remember, too, his own ability on the golf course and rifle range in the annual matches he arranged between Staff and Students.

So much more could be listed and no doubt others could tell numerous anecdotes of this truly "Guy's Man". His achievements have been great and well deserved and there is no doubt the constant, loving support of his wife, Audrey, has in no small measure ensured his many successes. Now all their friends and admirers join in wishing them both a long and happy retirement in health, peace and plenty.

F.N.G.

WHAT IS PLASTIC SURGERY ?

by

Nils L. Eckhoff

Clinical Lecture, June 13th, 1967

I have chosen the title for this lecture since I have come to the conclusion that undergraduate students do not seem to take much interest in this subject. This may be because they do not think it will be of much use to them in their final examinations, or because they feel there is something mystical about it, just as so many lay people are led to believe by foolish articles in the glossy magazines. How many times a mother brings her child to see us with a faint blemish from say, a minor burn or scald, expecting us to cause it to disappear by "plastic surgery", little realising that no surgery can be undertaken without leaving a scar of some sort.

What I hope to explain is that there is nothing at all mysterious about plastic surgery, which is no more than a careful application of the principles of general surgery. The most important are:—

(1) Carefully planned incisions.

(2) Gentle handling of tissues, using fine instruments throughout.

(3) Accurate haemostasis.

(4) Relief of all tension by undermining.

(5) Accurate and careful suturing, with fine sutures placed close to the edges, and close together. These are usually removed early, in three or four days on the face and neck, and if possible, within seven days elsewhere, for it has been shown, that if this is done, the sutures leave no mark. Nothing is worse than a scar with four or five sutures, widely spaced, whose marks remain for all time.

Sadly the war produced hundreds of cases of dirt-ingrained scars from bomb injuries, providing the surgeon excellent opportunities for practising the art of excision and suture. Today traffic accidents produce a number. Immediate cleansing, with a brush or fine curette, and careful suturing will save the necessity for many secondary operations. The plastic surgeon is becoming more and more associated with accident and emergency departments, which is for the benefit of all.

Having mastered the technique of careful suturing, the plastic surgeon is next directed towards the fascinating problem of local flaps. Whenever a defect has to be closed the first consideration should be the possibility of using local flaps, for the best tissue for closing a defect is that from the immediate neighbourhood. Most books on this subject contain traditional illustrations of varieties of local flaps, but before putting them into use, it is well to consider whether the new linear length of scar is justifiable. In many cases it may be decided that a well-matched graft with its necessary circumferential scar is preferable.

The principal local flaps are:—

(i) **Sliding flaps**, such as are constantly used in small elliptical excisions, with undermining on each side.

(ii) Advancement flaps, where the flap is designed on one side only, as at the junction of the cheek and nose.

(iii) Rotation flaps, relatively large, in the shape of the arc of a circle, where the elasticity of the skin of the big arc is used to cover a smaller defect at its extremity.

(iv) Transposition flaps, where the flap is lifted over a portion of skin, closing the secondary defect by direct suture, or with a graft in some less obvious place.

Z-plasty is a special and more useful application of transposition flaps. An incision is made in the form of a Z and after transposition the flaps are sutured in the form of an S. This is used with benefit in breaking up a contracted linear scar, and has recently been applied to pilonidal sinuses, and some pressure sores.

Direct flaps from one part of the body to another are available when the defect cannot be closed by local flaps. Abdomen to arm flaps, or flaps from one finger to another, are useful in traumatic losses, and cross-leg flaps for traumatic ulcers on the lower leg, often accompanied by a degree of chonic osteomyelitis. Such flaps require very careful planning, and necessitate fixation for about three weeks.

Indirect flaps may occasionally be required to transfer an area of skin and fat from the abdomen to a distant part, such as the head and neck or the leg. The arm is used as an intermediate host. A flap is designed on the abdomen (possibly in stages) and attached to the forearm, as far distally as possible. After three weeks or earlier if the vascularity tests are satisfactory, the flap is detached from the abdomen and transported with the arm to the distant part. Stiffness of joints may limit this type of procedure in older patients.

Tube Pedicles always seem to capture the imagination. These were evolved by Gillies in England, and Filatov in Russia, at approximately the same time, in the middle of the First World War. Like indirect flaps they require at least three procedures separated by about three weeks each, and there are possible hazards at each stage. But they form a very useful addition to the armamentarium, particularly in war wounds, and other big losses as in cancer surgery.

Free grafts are only considered when the above-mentioned methods are found to be undesirable or impractical. Every free graft is a bit of a gamble, for it can so easily be lost by a little haematoma formation between the graft and the recipient. Nevertheless, we expect to get and succeed in getting a very high proportion of good "takes" on clean surfaces. **Small deep grafts** (sometimes irreverently called pinch grafts) are useful in helping to cover a relatively large area when the available donor sites are limited, or when infection militates against the application of a bigger sheet of skin. The grafts are about 0.5 cm. in diameter and are placed about 0.5 cm. apart, but grow and coalesce so as to produce complete cover, albeit with a somewhat mottled appearance. They are therefore not very suitable for the face or hands.

Razor grafts (part thickness grafts) can be cut from the medial side of the upper arm or thigh, and most house surgeons and registrars very quickly learn to cut large and excellent grafts with the knives now available. We also have dermatomes, mechanical or electric. Remembering Lister's belief that the "best antiseptic is the living tissue cell", it is important to cover all raw surfaces as soon as possible. Hence razor grafts have a vast application in all branches of surgery.

Full thickness grafts, in which a piece of skin of the correct size is carefully dissected free with no fat, have a slightly less chance of complete take and should not be used, except on a surgically clean surface. Grafts of this nature taken from behind the ear give an excellent result after excision of skin tumours, such as basal celled carcinomata, from the face. Composite ear grafts consisting of two pieces of skin, with intervening fat (or cartilage) are useful in defects of the ala nasi, but must be limited in size, and do not always succeed.

Autografts of bone (from the iliac crest or rib) are most successful, but cartilage is a little disappointing from its tendency to curl. Homografts have limited usefulness, although much work is going on, in the attempt to overcome the rejection phenomenon. Corneal grafts are often succesful and skin homografts are useful as a temporary cover as in the burnt child. Heterografts have also been used in a similar manner for burns, but otherwise have no place.

Man-made substances are rather disappointing, for although often retained, they do not become incorporated, and may cause reaction and have to be removed later. Silicone rubber compounds (Silastic), which can be obtained in various consistencies, are promising, and are thought to be inert, and free of reaction.

Having studied the different methods available it is desirable to study the types of cases in which they can be applied. First and foremost comes the necessity for excisions and repair in carcinomata and basal celled carcinomata, although the former can be disappointing owing to the tendency to recurrence. It is hoped that with radiation and chemotherapy, such excisions will become less necessary in the future. Burns require difficult and prolonged treatment, not only in the early stages, but in the period of reconstruction later.

Congenital lesions and malformations form an interesting group, which can sometimes tax the surgeon's skill to the uttermost. One has only to reflect on the many operations that have been described and are still being described in the treatment of cleft lip and palate. In the treatment of syndactyly and of the bigger moles, grafting is often required. Reduction of bat ears, which often cause the patient much ridicule is an interesting little problem.

Plastic surgeons are often invited to deal with Dupuytren's contracture or other hand deformities. They also work closely with the dental surgeons in cases of fractures of the facial bones. Some progress is also being made in the treatment of lymphoedema.

It is inevitable that any surgeon interested in this field will be asked to deal with "cosmetic" problems. The borderline between a nose mis-shapened from injury or disease and one due to inherited characteristics is a narrow one. It is my belief that just as any patient has the undoubted right to have removed a wen or an ulcer which is a source of annoyance to him (or to anyone else), so I believe he has the right to ask to have the shape of his nose altered if it offends him, and if his request is within the bounds of surgery. Similarly, virginal hypertrophy of the breasts deserves reduction, but the patient may not come to surgery till the middle-forties, when the request is easily labelled "cosmetic". The treatment of hypotrophic breasts was always difficult but the results of moulded silicone rubber implants are extremely satisfactory.

Abdominal reductions in patients with enormous aprons who have done their best to diet, are eminently justifiable.

There will probably always be some debate as to whether these "cosmetic" operations are a fair claim on the National Health Service. Should a person with a self-inflicted tattoo occupy a hospital bed to have excision and grafting performed? The Ministry leaves the decision to the surgeon, who, if he considers the condition is causing physical or psychological harm, may decide to treat the patient. Whether or not a nose requires attention, for example, may evoke a different response from the patient, the practitioner, and the surgeon. It is remarkable how many patients come to see me with a letter from the doctor saying that he considers the request frivolous whilst I may well think it is perfectly well justified.

WILLS LIBRARY ANTIQUITIES

3. MASTER PETER LOWE SCOTTISHMAN AND CHYRURGION

By William Hill

Peter Lowe, who has a strong claim to be the author of the first comprehensive textbook in English on surgery, was born in Scotland in 1552. He was an army surgeon who spent 22 years in Flanders and France. In 1597 he made the first English translation of Hippocrates and projected several other books, but no copies of these are known to have survived, if in fact they were ever written.

In 1599 he founded the Faculty of Physicians and Surgeons of Glasgow. Three years before he had published his *Whole course of chirurgerie*. In 1612 he revised and enlarged it, added numerous woodcuts and published it as a second edition with the title:—

A discourse of the whole art of chyrurgerie. Wherein is exactly fet downe the definition, caufes, accidents, prognoftications, and cures of all forts of Difeafes, both in generall and particular, which at any time heretofore have been practized by any chirurgion. According to the opinion of all the ancient profeffors of the Science. Which is not onely profitable for Chyrurgions, but alfo for all forts of people; both for preventing of fickneffe and recouerie of health. Compiled by Peter Lowe Scottifman, Doctor in the facultie of Chirurgerie at Paris; and ordinary Chyrurgion to the French King and Navarre. Whereunto is added the rule of making Remedies which Chirurgions doe commonly ufe: with the Prefages of Divine Hyppocrates, the Second Edition, corrected and much augmented, and enlarged by the Author.

At this point he ran out of space on the title page. He did manage to mention the printer and date at the extreme edge.

Before the text starts there are three lengthy dedications, seven pages of poems written in his honour and four pages of authors quoted. The introductory chapter starts (the spelling has been modernised): "Considering with my self, that all men are naturally obliged to serve the commonwealth by some honest profession, and that no man is able to discharge that duty and benefit to his native country, except he learn, in his tender age, the Science wherein the

ornament thereof consisteth; after full deliberation I applied myself to the study of surgery, which is by the consent of all learned men, not only a science very profitable and necessary to all sorts of people, but also most ancient and honourable."

Parts of the text are written in the form of a catechism, question and answer. For example:—

"What method is to be observed of the Chirurgian in working his operations?"

First to know the disease, next to do the operation as soon as maybe, surely, without false promises or deceit to heal things that cannot be healed, for there are some, who void of knowledge and skill promise for lucre to heal infirmities being ignorant both of the disease and the remedies thereof."

In the section of "The tumour of the amigdalles," i.e. the tonsils, he described tracheotomy and he was prepared to operate to relieve strangulated hernia although "this operation must not be used but in great necessity and when the sick is strong, prognosticating still of the danger ne fefellisse aut ignorasse videaris."

Lowe describes the hernia thus:—

"The signs are these:—there cometh inflammation and the more ye press to reduce it, the inflammation is the greater, so it changeth the colour which is an evil sign, swooning and voyding of matter at the mouth are evil signs, and if the intestine be not reduced the patient dieth which happeneth through the narrowness of the dilatation. As for the cure, first rub the codd with oil of camomile and lay the sick on his back in such sort that his arse be higher than his head, reducing with thy hand little by little, pressing most on the place were it descendeth. If the faecal matter let [that is, prevent] the reduction use the remedies set down in Bubinocele and clysters to discharge the intestine; if by these remedies the intestine do not reduce but the matter wax hard with great dolor, ye shall make incision in the upper part of the cod, eschewing the intestine, thereafter put a little piece of wood up by the prolongation of the peritoneum near the hole of descent, the piece of wood must be round on one side and flat on the other, whereon ye shall make the rest of your incision and rub the descent with a little oil, so it shall easily reduce. If then it reduce not, the peritoneum must be incised and use the cautery Gastrographick and handle it as other wounds."

He recommends operation for varicose veins which he describes—"Varix is a dilation of the vein greater than natural, which happeneth in divers parts of the body as temples, belly, under the navel, on the testicles and matrix but chiefly in the legs, which is sometime one vein, sometimes divers together, full of thick, burnt melancholick blood letting [that is, preventing] action of the place."

In all, the book contains some 450 pages of surgical experience from wounds in the head to "the little hard tumour in the feet, commonly called cornes".

As usual, the book will be on display in the Wills Library, together with reproductions of some of his wood cuts (mostly borrowed from Ambrose Paré).

MEN AS NURSES

by

Denis Cobell

It is only during the last few years that the public has become aware of male nurses working in general hospitals, and many readers of the *Gazette* may be surprised to learn of a proposal to introduce male student nurses in the wards and departments at Guy's shortly.

The myth that nursing is strictly a woman's profession is slowly being eroded, and eventually there must be complete equality between the sexes unless there is to be a breakdown in the hospital service. There will be fewer young women available to enter the schools of nursing from 1970 onwards; of those who do enter, most will marry shortly after qualifying as State-Registered Nurses. Males will remain in the profession many more years than their female counterparts. Owing to this they will fill the top administrative and educational posts, and as Charge Nurses in practical ward work.

The number of men who have become State-Registered Nurses in recent years has steadily increased, at the same time, the number of young women passing this examination has slowly declined. The percentage of males who occupy higher nursing positions is proportionately higher than females even today. This recent innovation has accelerated in the last five years.

There is still widespread prejudice discouraging many youths from entering nursing: it is not always easy for a young man who seriously contemplates nursing to withstand the pressures from his family, friends and the general public, many of whom cannot quite understand a normal young man making this occupational choice. For this reason alone, the idea that nursing is solely for women must go, if boys possessing a standard of education comparable to the girls in training at Guy's are to be successfully recruited. It, unfortunately, remains true that the average grammar school boy confronted with the prospect of a nursing career may laugh, "What would the lads think?"

The growing complexity of many nursing procedures and the diminished time spent in bed by patients has gone a long way toward altering the "ministering angel" image, that people once held, of their nurses. If acceptance of male nurses has been slow, the professional organizations must receive some of the blame. The Royal College of Nursing and its underling, the Student Nurses' Association, have only admitted males into membership within the last decade.

Actually, men have been nurses for centuries. Under the guise of monks, knights hospitaller and serving brothers, they cared for the wounded in the Crusades, but during the last half-century, and until very recently, men have been widely evident only in mental hospitals. Since the unlocking of ward doors in mental hospitals, their role has advanced from the mere strong-armed custodianship it once was. The integration of psychiatric units with general hospitals has lead to additional numbers of males on the staff of these establishments.

At the moment, male nurses in Britain care almost exclusively for male patients. There is no reason why this situation should remain in the future. In my experience women patients have frequently been delighted at the presence of a male nurse! Men cannot practise midwifery in this country, unless they are doctors, although an obstetric certificate is an essential part of their nurse training in many parts of the U.S.A. The door to the maternity ward must one day be opened to male nurses, in order that their experience may encompass a wider field.

Difficulties in the doctor-nurse relationship have arisen in the past, but most physicians and surgeons are prepared to accept male nurses as colleagues nowadays. An admirable testimonial has been given by the director of nursing at New York's Sinai Hospital: she said, "Men can do anything in nursing that women can. They're extremely able. And they're generally more stable than women." This latter remark arises out of an inevitable situation if most female nurses are married. The rigours of family life are bound to affect a woman's ability to maintain steady hours of duty.

As a profession for men, as well as women, nursing salaries are low by comparison with other professions. Married men may feel this more acutely than spinsters, but the problem will only be solved by overall increases. Inequality of income according to sex has been condemned by the International Labour Organisation; reintroduction of such a measure in nursing would indeed be retrogressive.

The Society of Registered Male Nurses may have an easier task assisting its members today than it had in the past, but there are still a good many cobwebs to be blown out of the feminine minds. Men must be encouraged to enter nursing, and the stupid, old notions that have stood in the way, must be cleared away altogether.

It is exactly one hundred years since the first Parliamentary debate on Women's Suffrage, and it took over fifty years for the objective to be achieved. How long must males wait before they are admitted to every branch of the profession?

International Dermatology Meeting

Held at Guy's Hospital, 21st July, 1967

The reception committee in the colonnade occasioned much surprise from passers-by who found that Guy's was acting as host to a truly international, if informal, gathering of dermatologists from eight countries. They had been invited to visit us on their way to the Thirteenth International Congress of Dermatology, to be held later in the month at Munich.

Dr. Forman, Dr. Moynahan and Dr. R. S. Wells, who has succeeded Dr. Forman, have travelled widely in the States and are greatly indebted, like most of their colleagues, to their American friends for the hospitality they invariably receive there. They felt that this meeting would serve as a token of their appreciation.

The conference began at 2 p.m. with a clinical demonstration of twelve unusually interesting conditions. Prof. Butterfield then formally welcomed the members on arrival in the anatomy theatre before the nine short papers reflecting the department's interests were read. We were delighted to welcome Prof. Sulzberger again, Prof. H. Beerman, who apart from his dermatological achievements is an ardent admirer of Sherlock Holmes as Dr. Maurice Campbell will vouch for, Prof. Kerdal-Vegas from Venezuela, Prof. Popchistov and Dr. Andreev from Bulgaria and Dr. G. B. Dowling to whom we owe the photographic portrait exhibition of Guy's physicians, who took a special interest in dermatology, and of Guy's dermatologists, the first of whom was Dr. Barber, appointed in 1919.

This exhibition will remain on view in the Gordon Museum, and it is hoped that the British Exhibit at the Munich Congress will be on show later as the departmetns here and at the Hospital for Sick Children were responsible for its production.

After tea in the Gordon Museum, where the Towne collection aroused much admiration, the clinical cases were presented for discussion. The meeting then adjourned until 6.30 p.m., when members and their wives met at Westminster pier to board the m.v. *London Belle* for a river trip to Greenwich.

An excellent dinner was served in the Trafalgar Tavern. The menu bore an etching of the forecourt at Guy's on its cover and contained a brief history of Guy's as well as a list of all guests. The hospitality was generous, the wine flowed freely and the company lingered over liqueurs and coffee as it listened to some very amusing speeches well spliced with jokes and anecdotes. Dr. Geoffrey Dowling told us that our guests had been duly impressed and were thoroughly grateful for such a "compact and useful meeting" and for such a splendid dinner.

The meeting, despite the fast trot at which it was conducted, was indeed most useful. The visitors were glad to see some rare cases (e.g. pyoderma gangrenosum occurring in a man with ulcerative colitis hyalinosis cutis et mucosae) and were intrigued by a case illustrating the association between malabsorption and skin disorders in a 17-year-old girl with dermatitis herpetiformis and complete villous atrophy with a high blood titre of gluten antibody), as well as by a possible association between follicular mucinosis and malignancy.

In addition to two new syndromes, the pathology of a third syndrome was presented for the first time to an international audience, making it the seventh mucopolysaccharidosis, and a striking advance in intralesional steroid therapy was demonstrated.

THE PAPERS

Dr. A. Bowyer demonstrated the Porton High pressure jet injector, a painless means of intradermal injection which is used to treat Alopecia areata with cortico-steroids and is the most effective method at present in use for re-establishing hair growth.* This technique also has immense potential in the fields of mass immunisation and veterinary practice. The British armed services have shown considerable interest in the injector, but surprisingly the Ministry of Health have shown none, despite several invitations to see it demonstrated. Dr. Forman contributed his description of a new syndrome, haemorrhagic cheilitis. He was able to use one of Towne's wax models with identical appearances and history to illustrate this condition which seems to be confined to hysterical young women.

Dr. J. Verbov spoke about treatment of acne vulgaris with a new tetracycline, and Prof. I. Macdonald talked about some of the effects of diet on skin surface lipids which may throw light on some of the manifestations of acne, so-called "seborrhoeic eczema" and possibly cradle cap. He mentioned Mr. A. F. Llewellyn's work in analysing skin lipids and its wide application in investigating normal and abnormal variations in an as yet largely untilled field. Unfortunately, time cut short Dr. Blake's (Department of Pathology, Hospital for Sick Children) paper on the ultrastructure and histochemistry of strawberry marks in the skin but he was able to demonstrate clear differences in the enzyme pattern of these common blemishes. Prof. Mishima, of Wayne State University, Detroit, U.S.A., was obliged to compress his excellent paper on the Macromolecular Pathology of Pigmentary Disorders so that it is difficult to cover in a short review the ground that he covered, and to enumerate his new findings in this exciting field.

Dr. R. Harris (now of the Institute of Neurology, late of the Hospital for Sick Children) reminded the meeting of the significance of leukodermic macules in establishing the diagnosis of tuberose sclerosis in conjunction with infantile spasms, as they are often present at birth and in any case precede the other cutaneous manifestations by many months or years.

Dr. Moynahan described a new syndrome in which there is a profuse progressive lentiginosis (i.e. "Multple moles") associated with a short stature and a progressive multiple cardiomyopathy; this is a heredo-familial disorder. He noted that the father of the case shown was found dead by his fallen motor-cycle with no evidence of any accident. Dr. Moynahan felt that some cases might have been missed in the past before pathologists became interested in cardiomyopathy. In this respect it is of interest to note that Lord Brock was one of the

*B.M.J., 25th December, 1965, article by Drs. E. J. Moynahan and A. Bowyer.

first to recognise obstructive cardiomyopathy in the living subject, about the same time as Dr. Teare recognised it at forensic autopsy. Certainly in anybody with more than 80 "moles" one should suspect either cardiac malformations or a cardiomyopathy (i.e. E.C.G. changes). Dr. Suzanne Alexander read the last paper, which discussed the immunological aspects of pyoderma gangrenosum in ulcerative colitis.

The visitors in return were able to help with suggestions of treatment, in particular for a case of mycosis fungoides. Dr. Anne Maguire (whom we were glad to welcome back) found that a combination of chlorpromazine and cyclophosphanide produced some remarkable remissions in advanced cases.

A frequent comment was of surprise at the size of the dermatological department which is certainly compact by any standard, as it consists of one room. Wealth has its advantages and attractions. One dermatologist has been tempted by offers of a university chair with 2,000 sq. ft. of laboratory space with an appropriate budget and staff for research; his starting salary to be in excess of a consultant in the N.H.S. "Drain" will no longer serve to describe the torrent which will be pouring across the Atlantic unless things are remedied in this country.

A possibly more successful attempt is being made to persuade one of the department's "back-room boys" to emigrate by awarding him a scholarship to work in America. Americans are appreciative and have the means to aid research, and if they are unable to attract talent will pay that talent to work in its own country. Guy's is, like most hospitals, short of funds and as long as finance is not forthcoming in generous amounts the staff will have difficulty in realising their full potential. When will our senior administrators and ministers learn that the hallmark of medical progress is active on-going research in properly equipped and staffed teaching hospitals—both undergraduate and graduate? By present standards Britain is becoming a medically underdeveloped country. The French, unlike ourselves, recognise that they are medically underdeveloped and are doing something about it. As Lord Brock has said, the N.H.S. needs a large injection of capital, possibly as much as several times the present annual expenditure spent over several years.

Dermatology may seem to be a less urgent branch of medicine, yet it has much to offer as a field for research in basic medical science as both Bright and Addison knew, for they chose dermatological subjects for their Doctorates of Medicine at Edinburgh University.

The Department of Dermatology would like to thank the patients for their co-operation, the Governors and the officers of the medical school for their help, the dermatological firms for their services as couriers, and British Schering, Inertia Switch Co. (a British firm), Leo Laboratories, Pharmax and E. R. Squibb and Sons for their generosity which made this conference possible.

J.C.R.

OBITUARY

Dr. J. D. S. Thomas

The death occurred in a road accident near Truro while on holiday of Dr. J. D. S. Thomas of Radcliff-on-Trent, Nottingham.

Dr. Thomas qualified at Guys in 1925 and after being House Surgeon to the late A. R. Thompson, took his diploma in Tropical Medicine and entered the Colonial Service in East Africa. Returning to England he settled in general practice at Radcliffe on Trent where his devotion to his patients and cheerful presence soon made him a well loved and deservedly popular figure.

His contemporaries at Guy's will remember him for his prowess in many sports. He played in the outstanding rugger team Guy's fielded in the 1920s, playing in inter-hospital cup finals. He also represented the hospital in athletics but it was in the boxing ring he excelled. The famous referee Eugene Corri once tried to persuade him to turn professional after watching one of his fights in an inter-hospital contest.

When he retired a few years ago from practice his many patients and friends made a presentation to him which was a genuine expression of affection and gratitude.

The tragedy of his death has been deeply felt in the community and much anxiety is also felt for Mrs. Thomas who was severely injured in the accident.

P.J.L.

NOTICES

Surgical Firms

Following Mr Eckhoff's retirement on August 18th, 1967, surgical firms will be as follows:—

Professor Sir Hedley Atkins and Mr. Glover
M. Wass and Mr. Brain
Mr. Blackburn and Mr. Beard
Mr. Lawrie and Mr. Maynard

Reallocation of beds

Mr. Lawrie.—Luke (M), 11; Dorcas (F), 9.

Mr. Beard.—Astley Cooper (M), 6; Martha (F), 6.

Mr. Maynard.—Naaman (M), 2; Esther (M), 2; Esther (F), 2; Astley Cooper (M), 3; Dorcas (F), 3.

Conservative Dentistry Course

Commencing on Wednesday, 18th October 1967, a course in Conservative Dentistry primarily for F.D.S. candidates will be held at Guy's Hospital Dental School. The Course will consist of six sessions, from 6 p.m. to 8 p.m. on 18th, 20th, 25th and 27th October and 1st and 3rd November 1967. Fee: £10 10s. 0d. Further particulars and forms of application, which should be returned as soon as possible and not later than 9th September 1967, may be obtained from the Dean, Guy's Hospital Dental School, London Bridge, S.E.1.

QUIZETTE : Geriatric Medicine

1. In Multiple Myelomatosis :
   (a) The E.S.R. is often markedly raised; (b) X-rays of the skull may be helpful in diagnosis; (c) Bence-Jones protein is found in the urine in all cases; (d) Plasma cells are present in abundance in the peripheral blood; (e) Occurs mainly in young people.

2. *In Parkinson's Disease :*
   (a) Tremor is present at rest; (b) The gait is high stepping and very slow; (c) On passive movement, the rigidity is of the "Clasp knife" variety; (d) It is important to give the patient as much rest as possible; (e) Drugs are more effective for tremor than for rigidity.

3. Paget's disease of bone (Osteitis Deformans) :
   (a) Seldom seen before the age of 50; (b) Lesions are distributed uniformly throughout the bones (c) Serum calcium and phosphorus are elevated; (d) Osteogenic sarcoma may be an uncommon late complication; (e) Serum alkaline phosphatase is always normal.

4. In the clinical examination of an elderly person :
   (a) Absent vibration sense to the knees is abnormal; (b) It may be normal to find absent ankle reflexes; (c) There may be no chest pain with proven myocardial infarction; (d) Polyneuropathy may be the first manifestation of carcinoma of the bronchus; (e) Subacute bacterial endocarditis is unlikely in the absence of pyrexia.

5. Hypothermia :
   (a) Severe sytemic illness is always a precipitating cause; (b) Tachycardia is common at temperatures under 90° F. (32.2° C.); (c) Serum Amylase may be elevated; (d) There may be a characteristic wave pattern on the E.C.G.; (e) Bronchopneumonia is a common complication.

6. In old people :
   (a) Barbiturates are useful sedatives; (b) Oral Hypoglycaemic drugs have no place in the treatment of diabetes; (c) Ephedrine may cause retention of urine in males ; (d) Liquid paraffin is a safe aperient; (e) Monoamine oxidase inhibitors may precipitate cerebral thrombosis.

7. In the following bone diseases :
   (a) Long-standing rheumatoid arthritis is probably the commonest cause of amyloid disease; (b) Osteomalacia can occur in certain malabsorption states; (c) Osteoporosis of the spine can be a very painful condition; (d) Gout is rarely seen in women; (e) Primary generalised osteoarthritis seldom affects the terminal interphalangeal joints.

8. In the following blood conditions :
   (a) A poor nutritional intake may be relevant in iron deficiency anaemia; (b) A course of cytamen injections will cure pernicious anaemia; (c) Folic acid can arrest the progress of subacute combined degeneration of the cord; (d) Polycythaemia vubra vera may lead to frank leukaemia; (e) The purpura of scurvy is caused by deficiency of platelets.

9. Incontinence in old people :
   (a) It is a symptom and not a disease; (b) It may be improved by treating successfully an underlying urinary infection; (c) If present with severe mental impairment, the prognosis is usually poor; (d) May be associated with extensive bedsores; (e) All the above statements are correct.

10. In Geriatric units :
(a) Syncope may be the presenting feature of heart block; (b) Dementia is an acute condition which is usually reversible; (c) Constipation could be a symptom of a depressive state; (d) Subacute intestinal obstruction in a bedridden patient may be caused by faecal impaction; (e) Extensive bedsores may cause an elevated blood urea.

11. In which of the following conditions is the E.S.R. usually fairly normal :
(a) Active rheumatoid arthritis; (b) Giant-cell arteritis; (c) Carcinoma ofprostate with bone secondaries; (d) Polymyalgia rheumatica.

12. Giant-cell arteritis :
(a) In 25% of cases the age of onset is 70 years or over; (b) It is a widespread vascular disorder not merely confined to the arteries of the scalp; (c) Blindness is a rare complication in untreated cases; (d) Vigorous steroid therapy will completely cure blindness; (e) Biopsy of the temporal artery is the only means of absolute proof of the diagnosis.

QUIZETTE ANSWERS

1. **a b**
In myelomatosis, which usually occurs after the fifth decade, Bence-Jones protein occurs in approximately half the cases and plasma cells are found mainly in the bone marrow. Radiological study of the skeleton shows widespread punched out osteolytic areas, best seen in the skull, ribs and pelvis.

2. **a**
In Parkinsonism, it is extremely important to keep the patient physically active and as ambulant as possible. The gait is composed of small shuffling steps and is often more of a run than a walk. The increased tone is present throughout the whole range of passive movements, affecting opposing muscle groups equally—usually intermittent (Cog-wheel) rigidity. Drugs appear to help rigidity rather than tremor.

3. **a d**
The distribution of the lesions is patchy so that normal bone may be found between affected areas. The serum Ca and P concentrations are normal, except during periods of immobilisation when they may be considerably raised and serum alkaline phosphatase, a measure of new bone formation or osteoblastic activity may be markedly increased.

4. **b c d**

5. **c d e**
Hypothermia may be due to exposure to severe climatic conditions or from normal lossof body heat if a poorly clad elderly person lies helpless or unconscious in an unheated room for one or more days. Bradycardia, slow auricular fibrillation and muscle tremors are common at temperatures under 90°f. Pancreatitis and particularly bronchopneumonia are associated complications. The so-called "J" wave may be seen on electrocardiogram. Ref: B.M.J. 4th January 1964. A. J. Rosin Vol. 1. P16—19. A. N. Exton-Smith.

6. **c e**

7. **a b c**

8. **a d**
Cytamen injections must continue for life since the gastric atrophy is permanent. Folic acid can worsen subacute combined degeneration. The purpura of scurvy is thought to be caused by nutritional changes in the capilliary endothelium.

9. **e**
Faecal incontinence is half as common as urinary incontinence and is an easier problem to deal with as the bowels operate less frequently than the bladder. Brain damage due to vascular disease is the most common cause of incontinence, which may be worsened by sedatives and tranquillizors. Ref: symposium Incontinence in old people, Stubhill hospital, Glasgow N. 1. 13th July, 1966.

10. **a c d e**
Dementia is a chronic state and rarely reversible.

11. **None**
The E.S.R. is markedly raised in all the listed conditions.

12. **b e**
This is a disorder of the elderly, almost 80% of cases the age of onset is 70 years or over. Blindness, unilateral or bilateral, is one of the most striking complications (up to 50%), usually has an abrupt onset and is irreversible. Steroid therapy (40-60mg. prednisolone daily) if instituted early enough can undoubtedly prevent blindness.
Ref: Hospital Medicine June 1967, S. P. Meadows 835-840.

Compiled by H. M. Gillespie.

CORRESPONDENCE

Herpes Zoster and Chicken Pox

SIR,— Dr. Ian McGill is to be congratulated on his quizette on infectious diseases. I would like to discuss the relationship of herpes zoster and chickenpox. I would disagree with him that herpes zoster does not occur in people who have never had chickenpox. This almost amounts to saying that all forms of chickenpox are the same, and I personally do not think that this is true. I think there is a form which is associated with chickenpox and a form which is not associated with chickenpox, and this falls in with the way that many different viruses attack the central nervous system. I would agree with him that chickenpox can occur simultaneously with herpes zoster, but to say that 30%-50% of cases of herpes zoster have a concomitant chickenpox rash I think is completely wrong. It must have been a very special epidemic and there is no doubt at all that viruses do act in peculiar ways at peculiar times. For example, I once had an epidemic of mumps where the submaxillary glands were attacked in over 25% of cases, although the disease really does merit the alternative name of parotitis as this is usually attacked in other epidemics. Also I have seen many cases of herpes zoster which have been exposed to chickenpox. This is the point which I would like to stress because it is most important. For example, I have seen two grandparents who have got herpes zoster after being in contact with their grandchildren, and it is notorious that the older one is, the more likely one is to develop postherpetic neuralgia, which is very often almost incurable in the aged. In fact, I have taught for a long time that grandparents should be kept away from children with chickenpox, and I think this is just as important as keeping pregnant women away from rubella.

Lastly may I say that I have also recently seen a very severe case of herpes zoster which occurred after exposure to another person with herpes zoster, both of these in old ladies. I might also add that in my experience with chickenpox I have only once seen a concomitant rash which was typically herpetic.

Yours, etc.,

R. E. SMITH,
Area Director of
Postgraduate Medical Education
Birmingham

Hill House,
Near Rugby.

Dental Auxiliaries

SIR,—My article about Dental Auxiliaries in the Guy's *Gazette* of July 22nd was written as an informative account of the Auxiliary experiment. I am a student and as such have no knowledge of General Dental Practice. However, I have set out the following points which Mr. Paterson might find of use in answer to his letter of August 5th.

Mr. Paterson mentions the lack of steps taken to establish a differential in the public mind between the Auxiliary and the Dental Surgeon. But surely no such differentiation is necessary. An Auxiliary is trained for two years to fill teeth with amalgam and silicate restorative materials in children of school age. By law she cannot treat adults and there must be a registered Dental Surgeon present at all times when she is working. Under such restrictive conditions how can she be confused with a Surgeon of five years training who can perform any type of conservative, prosthetic, endodontic, preventive or surgical dental treatment on any patient? I feel that there is no more likelihood of the Auxiliary becoming indistinguishable from the Dental Surgeon, than for a Physiotherapist, who is, after all, a Medical Auxiliary, becoming indistinguishable from an Orthopaedic Surgeon.

The second point raised refers to the loss of Auxiliaries following marriage. This criticism is not, however, restricted solely to Auxiliaries but is applicable to any woman employed in any craft, trade or profession. Many Auxiliaries continue to practise following marriage and of those that leave, a large number will return to work in later years. If only one Auxiliary left practice for any reason, then we would not be receiving, to use Mr. Paterson's phrase, maximum cost effectiveness, but surely the same arguments must apply to female Dental Students Guy's Hospital Dental School accepts between 15 and 20 per cent of girls each year in its intake to study for the B.D.S. degree. Will the country receive maximum cost effectiveness from those girls if any of them give up dentistry to have families? And it costs considerably more to train a Dental Surgeon than an Auxiliary.

The final point is concerned with Auxiliaries learning to fill teeth with amalgam and silicate materials in two years when a Dentist, who studies for five years, spends the majority of his time doing similar work. This may be rephrased by saying that the Auxiliary is "taking the bread from the Dentist's mouth". But this is just not true. There is a bottomless well of conservation treatment to be carried out and the use of Auxiliaries to perform some of the work on children surely cannot encroach upon the work done by the Dental Surgeon, especially when it has been shown from Government statistics that the number of children in maintained primary and secondary schools will rise by at least two million in the next eight years. Furthermore Auxiliaries are not permitted to work in General Practice but are restricted to Local and National Authority Health Services. It is in this branch of the Service that there are difficulties in appointing staff, and the Auxiliaries therefore help to maintain a valuable social service which might otherwise fail. Auxiliaries are also able to spend much time with children to gain their confidence before treating them. Thus they become 'conditioned' to dentistry and make excellent patients for future treatment to be carried out by a Dental Surgeon.

As Mr. Paterson said, Auxiliaries are with us. I feel that they have come at the right time and are making a valuable contribution to a heavily overloaded community service. I am also convinced that as the value and the high standard of their work become more generally appreciated, opposition by the Dental profession will diminish and all Surgeons and Auxiliaries will work side by side to promote better standards of Dental Health throughout the community.

Yours, etc.,

PAUL W. F. LAMBDEN

East Wing,
Guy's Hospital,
London S. E. 1.

SIR,—Mr. Paterson's letter on dental auxiliaries interested me very much. My own profession of nursing makes great use of auxiliary help. In actual practice it has had the effect of upgrading the trained nurse, and I personally have never been mistaken for a nursing auxiliary. The distinction can easily be made by uniform or a badge.

One has only to work for a special dental practioner in the Health Service to realise that he must be working well below the intellectual and practical capacity that was required of him to enter dental school. The author himself proclaims this when he says these girls are trained in two years to do work which occupies a large amount of a dental surgeon's time. I understand furthermore that these girl's do the work with refreshing enthusiasm and are most conscientious.

With regard to the second point about marriage wastage, I would say cods-wallop to this Prince Albertian's sentiment. Most modern women work until they become pregnant and return to work when their children are older. I look forward to at least another twenty years' pofessional life, having done just this. More than half the public health service staff in this country are married women.

Yours, etc.,

Mrs. JOAN BAILEY
S.R.N. R.S.C.N. Queen's Nurse.

6, Neville Close,
West End Common,
Esher, Surrey.

By the Roots

SIR,—I was very interested in Dr. Fullerton's report on Morbid Anatomy in old age.

I think she has made a slight mistake in her quotation of Jaques description of the stages of life in "As You Like It".

It should be:—

Last scene of all
That ends this strange eventful history
Is second childishness and mere oblivion
Sans teeth, sans eyes, sans taste, sans everything

I may mention that I took my L.D.S. from Guy's in 1906 and still have 26 of my own teeth and still do a little practice.

Yours, etc.,

O. J. ROOTS

Berkeley House,
186, High Street,
Rochester, Kent.

Potty

SIR,—Passim (5th August) on this subject started well with the promise of objectivity, but regrettably progressed to a degree of cant only equalled by that the author criticised. It certainly did not add up to a reasoned argument and, to my mind, did nothing but harm to the writer's professed cause.

Whatever one may feel about the rights or wrongs of legalising such drugs as hashish, dogmatic statements unsupported by facts are unhelpful, and it is particularly sad that they should originate in a seat of learning based on scientific study.

Finally, I feel an argument based on a comparison with tobacco leaves much to be desired. How many of us in the Medical Profession, I wonder, do not wish cigarette smoking were in the present position of hashish, i.e. an illegal "soft" drug?

Yours, etc.,

D. J. STOKER

71, Blenheim Crescent,
Albrighton,
Wolverhampton, Staffs.

SIR,—Passim (5-8-67) does a service in asking its readers to give some calm thought to the problem which "pot" has produced.

I may live a sheltered life, but I have not been aware of any "mass Puritanical hysteria . . . being whipped up throughout the country".

I have read a full page advertisment in *The Times* which might be described as "appealing to the most base and irrational elements of the individual intellect". But this was suggesting that people should be encouraged to take a hallucinatory drug and appealing to that "base and irrational element" in all of us, which thinks that we know better than anyone else, and is unable to benefit from the experience of others.

Your own page and quarter could hardly be described as a calm, rational contribution to the problem. There are several flights of fantasy in it. I would mention just two. It is wrong to suggest that our actions do not affect people. Even our breathing affects them by the liberation of carbon dioxide—or even pathogenic organisms—and we can hardly do less than breathe. There is evidence that those who take "pot" find its properties so fascinating that its consumption becomes an end in itself. Responsibilities to their families and employers become ignored, so that other people are quite definitely harmed.

You say that people are permitted to smoke and expose themselves to a greater chance of lung cancer, so why not let them smoke "pot" and run their own risk of possible addiction, and the other nasty things that some say would follow?

This is surely a completely irresponsible statement—particularly coming in the editorial of an official hospital publication. There is a difference between writing a letter in the correspondence column of a magazine and writing what is inevitably regarded as an "official" commentary on some aspect of current events.

If there is anything at all in a rational, scientific approach to life in general, and medicine in particular, it tells us that smoking cigarettes greatly increases one's chances of getting lung cancer. Those who know what miseries this involves would be wrong not to try to prevent people from exposing themselves to such a risk.

A person who sees a child rushing towards a precipice while chasing a balloon would be wrong to say: "If he wants to risk falling over the elge, why should I stop him?" Before encouraging further the taking of "pot", we should at least call a halt until we are sure we are not starting people on a habit they will bitterly regret later. We *do* become addicted to things—even though they are not classified as drugs of addiction. The experience of many who have tried to give up smoking is evidence of this. If cigarette smoking were something that was just starting in this country, and we knew of its association with lung cancer, we should be irresponsible if we tried to encourage it. In our present state of knowledge, you are irresponsible in encouraging the increased use of cannabis.

Yours, etc.,

T. H. S. BURNS

Department of Anaesthetics,
St. Thomas' Hospital,
London, S.E.1.

SIR,—The *Daily Express* article of August 8th. It is beyond my comprehension how you can print such trash in your *Gazette* let alone advocate it. If the authors are medical men they should be struck off the register. Responsible medics are having enough trouble today trying to cure these stupid people without the writers of this article deliberately trying to encourage drug taking. If they themselves or particularly their children became "hooked" they would soon change their ridiculous and dangerous views.

Yours, etc.,

R. MURPHY

24, Poplar Grove,
Sale,
Cheshire.
August, 8th.

A man of Guy's there was, whose face
(Sometimes at rest, more often in grimace)
Became a symbol on T.V.
Of Kingship in psychiatry;
His every word on matters of the mind
Was much the most important of its kind.

His name, though some may find it odd,
Became synonymous with God,
And then, believe it or believe it not,
He stated that the use of 'pot'
should not be classed with other crimes—
He signed an advert in the *'Times'*.

Some of us with sons and daughters
(Bread upon this nation's waters)
Find it hard to stop the smoking
For our children think we're joking—
All our stories *must* be lies,
They prescribe the stuff at Guy's.

M.R.G.

The Waiting Game

SIR,—The lack of consideration for patients by your dispensary, leaves me fuming every time. I understand that if they are under-staffed it may take a considerable time even to put made-up pills into a bottle. Nobody minds coming back later or even the next day to collect, but to have to queue in person for at least an hour each time, just to hand in one's prescription, when a simple number with a pencil, would keep prescriptions in the right order, seems inconsiderate to the point of arrogance.

I am a busy executive and my pregnancy has another three months to term, this means that if there are no complications, I have at least another three prescriptions to collect. On each occasion I shall wait ten minutes to hand in my prescription and then I shall blow a loud whistle until my prescription is accepted. If the ministry of health is too affected by the squeeze, I am prepared to donate a lead pencil to the dispensary for the purpose of writing numbers on prescriptions. I would like to add that I am extremely satisfied with the courtesy and kindness of the doctors and nursing staff at Salomon's Centre.

Yours, etc.,

ELIZABETH KIERAN

54, Parkside,
Vanbrugh Park,
London, S.E.3.

The previous letter was shown to the Chief Pharmacist, whose reply follows:—

SIR,—In reply I can only say that I would like to know when Mrs. Kieran had to queue in person for at least an hour just to hand in her prescription. Although we are extremely short of staff we do operate a system of numbering prescriptions whereby patients are dealt with in strict rotation, can sit in the waiting room or visit the canteen without danger of losing their turn or, if preferred can call back later on the same or following day to collect their medicine. This system operates between approximately 10 a.m. and 5 p.m. daily except on Saturday mornings or when the number of patients waiting falls below six.

I appreciate the offer of a pencil but an extra pair of hands to attach numbers to prescriptions would be more to the point.

Yours, etc.,

J. MOORE,
Chief Pharmacist

Guy's Hospital,
London, S.E.1.

OBITER DICTUM:

Dr. McH*RDY-YNG**: "Personally, I do think this patient has gonadal atrophy, Sir."

Dr. Hst*n**: "I don't agree. You must have low standards!"

90 Years Ago

The School Building . . . . September, 1877

But little progress has been made towards the completion of the new Physiological laboratory and classrooms, since the mention made of them in our last number, owing to the recent general strike among the masons throughout London, caused by their demanding a penny an hour more wages, and an hour a day less work, giving as their reason for their demand, the high price of provisions and the flourishing state of the building trade, as well as their inability to get to their work as early as formerly, owing to the discontinuing of the early workman's train on the Metropolitan and Surban line. To this demand the masters refused acquiecence, maintaining that neither was trade sufficiently prosperous nor the want of early trains a sufficient excuse for their granting the men's request.

Thus, amongst other, the contractor for our buildings was thrown back in his work and would have lost his contract, had it not been that he gave way to his men, thereby putting himself twenty-five pounds out of pocket.

50 Years Ago

From Passim August, 1917

It is extremely gratifying to read that hospital ships will be no longer liable to risk from torpedoes, on condition that a Spanish naval officer is on board and guarantees that the vessel is only used for transport of sick and wounded. There is still bound to be a certain risk from mines, but if the Germans really keep to their agreement the minds of the wounded during transit by sea ought to be relieved of much anxiety.

NURSING SECTION

STAFF CHANGES AND APPOINTMENTS

APPOINTMENTS

S/N A. R. Wood, S.R.N., R.M.N. (Royal Hospital, Portsmouth), to York Clinic.

CHANGES

Sister D. D. Fox, S.R.N., S.C.M., Q.N., from Victoria Ward to Nuffield D Floor.

DEPARTURES

Sister J. S. Parry, from Nuffield D Floor to a post as an Administrative Sister at New Hospital, Singleton Park, Swansea.

S/N A. R. Gunn, from Cornelius Ward.

S/N M. A. Joyce, from Diplock Ward.

S/N K. LaReau from Outpatient Department.

S/N F. M. Pearson, from Christopher Ward.

S/N J. Ross, from Ashley Cooper.

S/N E. M. Yorke, from Stephen Ward.

The following Nurses have passed the Final State Examination held in June, 1967:—

Allom, E. L.
Anderson, P. M.
Anstey, S. G.
Asburey, E. J.
Atkins, K. C.
Banks, S. M.
Bland, F. F.
Bowen, J. A.
Brooke, P. A.
Brooks, E. C.
Budd, D. M.
Cameron, J. E.
Cargill, C. M. S.
Chase, M. A.
Chorley, N. M.
Deakin, M. A.
Edwards, D. M. F.
Graham, C.
Harper J. B.
Ireland, S. C.
Jones, A. P.
Jones, F. E.
King, A. C.
Lakin, J. A.
Lambert, C. M.
Lampen, P. J.
Lawrence, J. A. M.
McCowen, J. M.
McIntyre, S. M.
Macpherson, C. A.
Mawson, S. E. S.
Maynard, A. M.
Merry, L. J. C.
Ombler, P. E.
Parsons, S. A. M.
Pinsent, J. M.
Platt, S. J.
Pritchard, P. E.
Pullom, E. A.
Rout, R. O.
Thompson, J. A.
Trees, R. P.
Viney, J.
West, J. A.
White, R. C.

Combined training with Moorfied Eye Hospital, E.C.1.
Cook, A. C.

Combined training with Nuffield Orthopaedic Centre, Oxford.
Roseveare, K. I.

SPORT

FACE-LIFT

The Hockey Club has at last obtained a second pitch at Honor Oak Park. After repeated attempts in past years, it came as a surprise that when measurements were taken it was found that another pitch could be included in the already available space.

On this wave of jubilation the Clubs Union Council quite rapidly passed the scheme.

However, news that Mr. Fred Taylor, the Assistant Groundsman, was leaving the H.O.P. staff for a post at Blackheath as Head Groundsman for the G.P.O. and further that there was no replacement plus the additional knowledge that Mr. Tom Chick the Head Groundsman was soon to start his holiday, all seemed sufficient to shelve the plan for yet another few months.

But these past few weeks have seen members of the Rugby, Hockey and Football Clubs re-marking the pitches for the winter season.

The 2nd XV Rugby Pitch has been transferred to in front of the Pavilion in place of the Soccer Pitch—which together with an extra Hockey Pitch has been fitted like a jig-saw puzzle into the Crofton Park area of H.O.P.

One question remains—can the bar be extended?

CRICKET

It is a rare event to see two individual centuries scored in an afternoon of club cricket but when Guy's played Lloyds we were presented with such an occasion.

Lloyds, batting first, declared at 207-5 after Hussey had scored 122—indeed his fourth century against Guy's this season. In reply it was Appleby, the Guy's captain, who took the honours by scoring 112 not out—an outstanding innings for which it would be hard to find a comparable performance from any Guy's batsmen in the last five years. However, the game resulted in a draw, with Guy's 186-8 at close of play.

London New Zealand were avengingly defeated by Guy's. London New Zealand declared at 168-7, with McMillan 125 not out—poor fielding allowed him to provide two-thirds of the oppositions score. However, Guy's gained a comfortable victory by 7 wickets with fine performances from Butchey with 65 and Gillham with 57 not out.

RESULTS

Guy's Hospital Water-polo tour, 1967

The Guy's water-polo team returned to London from the West Country well satisfied after their first ever tour, having won two and lost six of the eight matches played during the week. In spite of the seemingly poor results, the tour was a great success, for the general standard of the teams we played was above that of our usual opponents. During the week we played in a variety of pitches and conditions, ranging from mountainous freezing seas (Lyme Regis), driving rain across an open pool (Lymington), to a warm indoor pool (Yeovil).

For most of the team, playing in the sea before large crowds was a new experience, and at first they found the conditions quite unsettling. During the tour we were watched by well over one thousand people which must rank with the highest number of spectators for any Guy's club which has been on tour. Without doubt the club has benefited enormously from the tour and it is hoped that the knowledge and experience gained will enable us to do well in the coming Hospitals' league and the Knock-out Cup.

S. J. CHALLACOMBE

Team: D. Foulds, S. Challacombe, A. Froom, K. Howard, D. Davidson, P. Ashford, M. Adkins, G. Northcott, J. Wood.

Reports of individual matches

v. Junior Leaders Rgt. Won 12—5

Guy's began the tour against rather weaker opposition and eventually ran out winners 12—5. However, this was not without some anxious moments and some incredible misses during the early part of the game. At half-time Guy's led by 5—3, but better shooting and strength of our boys during the second half began to transform itself into goals and seven more were added

Scorers: S. Challacombe (7), G. Northcott (2), A. Froom (1), J. Wood (1), P. Ashford (1).

v. Lyme Regis. Lost 1—7

It was with some trepidation that we approached our first match in the sea, which began at 8.0 in the evening. However, encouraged by a crowd of 300 we braved the water but several players were affected by the cold before the end.

During the first quarter, Guy's had some difficulty in coming to terms with the swell of the sea and wind, and with passes going astray we had little possession against a competent Yeovil team, thinly disguised as Lyme. We did manage to limit them to one goal in spite of all this. The second quarter showed some improvement, and a nicely taken goal by Ashford put us back in the game for a spell before Lyme added two more. Soon after the start of the third quarter we were awarded a penalty, but the referee judged that Northcott

had moved his hand backward before shooting and the goal was disallowed. This seemed to inspire Lyme who scored two more goals in each of the remaining quarters to win 7—1, in spite of sterling efforts by Wood in the Guy's goal. Considering the alien conditions this was not a bad effort by the Guy's team, but we hoped to improve in the remaining sea matches, having been introduced to the perils of deep sea water polo.
Scorer: Ashford (1).

v. Weymouth. Lost 2—7
Guy's began in confident style and improved on their previous performance. Ashford gained the ball and a quick passing movement nearly brought Guy's an early goal. However, at the end of the quarter it was Weymouth who were leading by one goal. The strong Weymouth men scored two goals quickly in the second quarter and when they were awarded a penalty all seemed lost. However, Howard in the Guy's goal made a magnificent save, which was followed by a goal from Challacombe from the slimmest of chances. A tiring Guy's side let Weymouth score three more goals in the third quarter, none of them particularly good shots. Wood, who had replaced Howard in goal, now emulated the latter's feat by saving a penalty, and when Guy's were awarded one soon after, Challacombe made no mistake.
The last quarter saw a fighting side create several good chances, all of which were wasted by the Guy's forwards, and the final score of 7—2 was extremely flattering to Weymouth.
Scorer: Challacombe (2).

v. Exmouth. Lost 1—18
As we entered the water we were informed that we were playing virtually the complete Devon side. This only added to our trepidation and from the start our fears were seen to be well founded. During the first quarter Exmouth scored five goals, second quarter five goals, and in the third six goals to leave us 16—0 down at the start of the last quarter. At this stage Guy's tightened up considerably and Davidson scored a goal to the delight of the crowd, but two more by Exmouth, one a penalty, left the final score 18—1 and one of the biggest defeats in Guy's history. Exmouth were a superb all-round team and were classes above us in every department. The fact that we scored was our only consolation.
Scorer: Davidson (1).

v. Osmington Bay Won 7—4
Since we were playing another match in the evening, Guy's took this one at a leisurely pace, which probably suited our style better. A good shot by Northcott brought an early goal, the only one of the quarter. Soon after the start of the second quarter Osmington equalised, but two fine shots by Challacombe brought Guy's two more goals. Osmington came back with two more but a goal apiece by Ashford, Northcott and Challacombe left Guy's in a good position at the end of the third quarter. A goal to each team in the last quarter, with Guy's slackening off somewhat, left the final score 7—4, a win which was easy, but restored our confidence somewhat shattered on the previous night.
Scorers: Challacombe (3), Northcott (2), Ashford (1), Davidson (1).

v. Bridport. Lost 5—6
This was undoubtedly Guy's best performance of the tour and a game we fully deserved to win. A large crowd saw Guy's go quickly into the lead after a melée in the Bridport goalmouth, the goal pushed in by Davidson. Bridport soon equalised, but a fine shot by Northcott left us ahead at the quarter stage. Froom scored a great flick-on goal to put us two goals ahead, and with all the Guy's team moving well in the water, our chances seemed bright. However, a marking lapse and a fine move brought Bridport the equaliser and then the lead by half-time 3—4. A shot by Froom gained a corner and from his pass Challacombe shot Guy's fourth goal, but Bridport went two goals into the lead by quick passing movements. In the last quarter it was all Guy's, with the defence of Foulds, Wood and Adkins outstanding, and our fifth goal came from a left-hand shot by Challacombe, off the bar. Now Guy's struggled for the equaliser, only to be thwarted by the woodwork, and the final score was 6—5 to Bridport. Special mention must be made of our two goalkeepers who played splendidly throughout.
Scorers: Challacombe (2), Froom (1), Northcott (1), Davidson (1).

v. Yeovil. Lost 8—2
Guy's played their first match of the tour in an indoor pool, but having become accustomed to sea polo, took some time to settle down, but played progressively better throughout the match. We had a disastrous first quarter in which Yeovil scored three very good goals and a better second quarter in which they scored two. At this stage many Guy's passes were going astray which lost us the little possession we had. Things improved in the second half and from a corner by Froom, Challacombe pushed in the ball with his left hand, his right hand being held. By this time Foulds had (at last) got the better of his man, which caused Yeovil to change their tactics and limited them to one more goal in this quarter and two in the last. Towards the end Guy's were awarded a penalty, duly converted to make the score 8—2 in Yeovil's favour. Had Guy's tightened up their game earlier we might well have held Yeovil to four or five goals but it was still a satisfactory performance against better opposition.
Scorer: Challacombe (2)

v. Lymington. Lost 4—8
Guy's played their final match of the tour in appalling conditions, driving rain across an open air pool, having been kept waiting by the Lymington team for nearly an hour. From the start it was evident that the sides were fairly even, but the man of the match was the referee who reduced the match to a farce and the Guy's side to desperation because of some ludicrous decisions. Twice he signalled a free throw to Guy's, and as Guy's were characteristically thrashing their way up the pool he changed his mind leaving them stranded up field and the Lymington players with two gift goals. His mortal blows, however, were delivered in the second and third quarters when Wood in goal, and then Howard who replaced him were both judged to have let goals in when to everybody else they appeared to have made good saves.

Between whiles both Lymington and Guy's scored four goals although Guy's had by far the most possession and either hit the woodwork or crowded each other in front of the goal. The final score was 8—4 to Lymington in probably the least satisfying match of the tour. However, we were fully compensated in their club afterwards with both solid and liquid refreshment in ample if not sufficient proportions.
Scorers: Challacombe (2), Froom (1), Adkins (1).

CRICKET

GUY'S v. LONDON NEW ZEALAND

Result: won by 7 wickets

London New Zealand, 168 for 7 dec. (McMillan, 125 not out.)

Guy's, 169 for 3. (Butchey, 65; Gillham, 57 not out.)

This was a very satisfying win after our defeat by nine wickets last year. Once again, however, we allowed one of our opposition to score a "ton" against us; this one being notable for the fact that it was a very large proportion of our opponents' total. For Guy's Pearson (3 for 26) bowled well, although the rest of the bowling lacked penetration.

Guy's had to score at a brisk rate to get the 169 runs required to win. This was achieved due to the efforts of Butchey and Gillham giving Guy's their best start of the season. Butchey, batting in his most attacking form, did most of the early run scoring. Gillham started slowly, though he gave good support to Butchey. Later he took on a commanding role at the wicket, finishing the day with a broad grin and an unbeaten 57 not out.

Guy's reached their target with a few minutes to spare and then returned to the bar where, after his success in 1966, Mr. Turfitt was sadly missed.

GUY'S v. LLOYDS BANK

At H.O.P. 29th July, 1967

Result: drawn

Guy's won the toss and asked Lloyds Bank to bat on a greenish wicket that looked unprepared for the occasion. A fine catch by Butchey at short leg enabled Beacham to claim an early wicket, but Hussey and Young for Lloyds Bank pushed the score to 113 before Appleby was able to claim the next wicket. Guy's fielded poorly on this occasion, the slip fielders well below their usual form of this season. Hussey went on to cut his way to the fourth century against Guy's this season, as a result Lloyds Bank were able to declare at 207 for 5, leaving Guy's a fair chance of getting the runs.

Even Guy's had not realised what effects a little sun and drying wind would have on the wicket. Guy's were soon in trouble, Butchey and Gillham both back in the pavilion with only 15 on the board. Clark's appearance at the wicket boded well for Guy's; he scored a quick 16 before through no fault of his own he was caught in the gulley from a ball that cut up off a good length. Thomson and Silk were soon dismissed with a little help it was thought by the umpire, and with the score at 34 for 6 Appleby got off the mark. He then gave us as good display of aggression and sound defence as has been seen at H.O.P. by any batsman for at least five years. His hooking, pulling, and cutting were particularly fine and considering the apalling state of the pitch throughout the game his ability now and again to drive the ball through the covers was outstanding. Appleby was ably supported by Davies, who although scoring only six did his job admirably by staying in. After he was finally out, with the score at 125, Crafts was able to support Appleby, who at the close was 112 not out, and Guy's were 186 for 8 wickets.

A truly remarkable game of club cricket. *To see two hundreds in an afternoon is unusual*, but to see one of such high quality on one of the worst wickets of the season is something we will not forget for a long time.

Lloyds Bank, 207 for 5 dec. (P. B. Hussey, 122.)

Guy's, 186 for 8. (M. I. Appleby, 112 not out.)

D. B. A. SILK

HOSPITAL INFORMATION

APPOINTMENTS VACANT

GUY'S HOSPITAL AND SOUTH-EAST METROPOLITAN REGIONAL HOSPITAL BOARD

Applications are invited for the post of **Senior Registrar in Orthodontics.** The duties are to be shared between Guy's Hospital (six sessions) and the South-East Metropolitan Regional Hospital Board (five sessions) with attachment to the Woolwich Group and neighbouring Groups in S.E. London. Duties to commence 1st October, 1967, or as soon as possible thereafter. Forms of application are obtainable from, and should be lodged with, the Superintendent, Guy's Hospital, London, S.E.1, not later than **Saturday, 26th August, 1967.**

GUY'S HOSPITAL, S.E.1.

Applications are invited for the post of **S.H.O. in Clinical Pathology,** with appointment for one year from 1st October, 1967. Subject to satisfactory service the successful applicant will be re-appointed as Registrar for a further period of two years. Forms of application are *obtainable from the Superintendent,* Guy's Hospital, S.E.1, and should be returned not later than **31st August, 1967.**

GUY'S HOSPITAL DENTAL SCHOOL

Applications are invited for the appointment of **Senior Lecturer (Full-time) in the Department of Conservative Dental Surgery,** with duties commencing 1st October, 1967, or as soon thereafter as possible. Salary in the scale £2,590 x £115 to £3,050 (bar); £3,165 x £115 to £3,395, with superannuation.

Forms of application are obtainable from, and should be lodged with, the Dean, Guy's Hospital Dental School, London, S.E.1, not later than **29th August, 1967.**

HOUSE APPOINTMENTS

House Surgeons
To:

Professor Sir Hedley Atkins — Mr. M. J. B. Farebrother, 6 *months*
Mr. Wass — Mr. R. P. Juniper, 3 *months*
Mr. Blackburn — Mr. A. Kumar, 6 *months*
Mr. Lawrie — Mr. J. P. H. Jago, 3 *months*
Mr. Glover — Mr. J. H. Topham, 3 *months*
Mr. Brain — Mr. A. Loach, 6 *months*
Mr. Beard — Mr. R. H. S. Lane, 3 *months*
Mr. Maynard — Mr. J. Newman, 6 *months*

House Physicians
To:

Dr. Mann, Dr. Scott, and Dr. Bishop — Mr. K. Kermani, 3 *months*; Mr. J. G. Pickering, 6 *months*
Dr. Hardwick, Professor Trounce, and Dr. Deuchar — Mr. P. M. Wood, 3 *months*; Mr. P. D. M. Ellis, 6 *months*
Dr. Baker, Dr. Houston, and Dr. Grimble — Mrs. C. A. Topham, 3 *months*; Mr. D. E. P. Shapland, 6 *months*
Dr Kauntze, and Dr. Joiner — Mr. D. S. Robins, 3 *months*; Mr. R. C. G. Rowe, 6 *months*
Professor Butterfield, Dr. MacLean, and Dr. Lessof — Miss H. Scott, 3 *months*; Mr. R. A. C. Hughes, 6 *months*

House Surgeon to the Surgical Unit
Mr. D. P. G. Griffiths, 3 *months*

Gynaecological House Surgeon
Miss S. Haslewood, 6 *months*

Throat and Ear House Surgeons
Mr. N. C. Hamblyn, 3 *months*
Mr J. L. Williams, 6 *months*

Orthopaedic House Surgeons
Miss R. C. Radford, 3 *months*
Mr. P. J. Leopard, 6 *months*

Genito-Urinary House Surgeon
Mr. D. F. H. Wardle, 3 *months*

Children's House Physicians
Mr. R. J. Leete, 3 *months*
Mr. B. W. R. Moore, 6 *months*

House Physician to Dr. Bishop and Radiotherapy
Mr. W. R. L. Clemmey, 6 *months*

Casualty Officers
Mr. J. M. Richards, 3 *months*
Mr. J. F. Searle, 3 *months*
Mr. A. L. G. Peel, 6 *months*
Mr. C. C. Penney, 6 *months*
Mr. G. F. Rushforth, 6 *months*
Mr. N. Irish, 3 *months*

Resident Obstetricians
Mr. D. L. Ingram, 3 *months*
Mr. C. G. Leach, 6 *months*

Neurological House Physician
Mr. R. B. Stott, 6 *months*

Dermatological House Physician
Mr. R. J. Eady, 6 *months*

House Physician in Child Psychiatry
Readvertised, 6 *months*

House Surgeons to the Thoracic Unit
Mr. A. J. M. Proctor, 3 *months*
Mr. A. G. Spitzer (S.H.O.), 6 *months*

House Physicians in Clinical Pathology

Mr. D. Leng
1 *month*
Mrs. A. Markanday
3 *months*

House Physicians in the Department of Psychological Medicine

Mr. S. Bhanji	1. 9.67—30.9.67
Mr. B. H. Anstee	1. 9.67—30.9.67
Miss W. M. Rostron	1.10.67—31. 3.68
Mr. M. O. Aveline	1.10.67—31. 3.68

R.M.O.s in Nuffield House

Mr. D. J. Hendrick
4 *months*
Mr. P. R. Dorken
6 *months*

Resident Anaesthetists

Mrs. I. M. J. Mathias
3 *months*
Miss H. Hale
3 *months*
Miss S. A. Kidd
6 *months*
Mr. A. H. Morris
6 *months*

Children's House Physicians at the Evelina Hospital

Mr. B. C. O'Moore	1. 4.67—30. 9.67
Mr. J. Stuart	1. 6.67—30.11.67
Mr. C. L. Newman	1. 8.67—31. 1.68
Mr. R. A. Y. Pietroni	1.10.67—31. 3.68

Casualty Officer at the Evelina Hospital

Mr. S. C. D. Mehta
6 *months*

ST. OLAVE'S HOSPITAL

House Physicians to Dr. Mason and Dr. Cox:
Mr. P. J. C. Trenchard
3 *months*
Miss A. de C. Evans
6 *months*

House Surgeon to Mr. O'Flynn:
Mr. S. C. A. Davoodbhoy
3 *months*

House Surgeon to Mr. Lewys Lloyd:
Mr. C. Bologna (S.H.O.)
3 *months*

Gynaecological House Surgeon:
Miss J. K. Tateossain
6 *months*

Casualty Officer:
Mr. J. G. Cochrane (S.H.O.)
3 *months*

Clinical Pathology:
Miss P. Furnell (S.H.O.)
Miss Hussain (S.H.O.)

NEW CROSS HOSPITAL

House Physicians in Medicine and Geriatrics:
Miss E. A. Cosgrove (S.H.O.)
3 *months*
Mr. D. A. Ryland
3 *months*
Mr. J. C. Robertson (S.H.O.)
6 *months*
Mr. A. P. Warin
6 *months*

Orthopaedic House Surgeons:
Mr. El. Mariah (S.H.O.)
3 *months*
Mr. D. R. H. Vernon
3 *months*

BECKENHAM HOSPITAL

House Physician:
Miss R. A. Baker
6 *months*

House Surgeon:
Mr. R. F. J. Matthews
6 *months*

LEWISHAM HOSPITAL

House Physician to Dr. Price
Mr. P. Ransley
3 *months*

House Physician to Dr. Roberts:
Mr. B. W. Eliot
3 *months*

House Surgeon to Mr. Williams:
Miss C. Garrett
3 *months*

House Surgeon to Mr. Le Brun:
Mr. E. P. Davis
6 *months*

MILLER HOSPITAL

House Physicians to Dr. Lessof and Dr Hartley:
Mr. T. Gibson (S.H.O.)
3 *months*
Mr. D. L. Beales
3 *months*
Mr. A. B. Bevan Jones
6 *months*

House Surgeon with Urology:
Mr. N. H. White
6 *months*

House Surgeon with Orthopaedics and Gynaecology:
Mr. A. H. Osborne
3 *months*

House Surgeon with E.N.T. and Ophthamology:
3 *months*

ORPINGTON HOSPITAL

House Surgeon:
Mr. M. A. Preece
6 *months*

PEMBURY HOSPITAL

House Surgeon to Mr. Gibson:
Mr. R. K. Jacoby
6 *months*

ST. NICHOLAS HOSPITAL

House Physician to Dr. Scott:
Mr. W. P. Onyeama
3 *months*

A. W. HIND,
Acting Superintendent

PASS LISTS

ROYAL COLLEGE OF SURGEONS OF ENGLAND

Primary F.D.S.

D. Boulton	W. T. Lamb
A. J. Bowman	R. Sri-Pathmanathan
A H. Brook	

UNIVERSITY OF LONDON

Special Second Examination for Medical Degrees

B. F. Akasheh	P. L. Neustatter
B. S. Avery	C. J. Noble
G. T. Cheney	J. A. Quant
B McK. Crighton	D. F. A. Richards
D. A. Curson	D. A. Rosenberg
S. J. Doyle	M. D. Rutland
D. L. Edbrook	P C. Sharpe
G. M. A. Heaton	K. J. B. Sommi
D. T. Langford	T. J. Storrs
E. G. Latimer-Sayer	Catherine Thorne
N. Longhurst	M. N. Vellacott
P. G. McAndrew	C. B. Vulliamy
J. M. Morsman	T. H. Watford
H. Nath	A. J. West

Special First Examination for Medical Degrees

P. G. Lunn	M. P. Powell
C. J. F. Manning	J. Y. Wakeham
Clare H. A. Moynahan	

The following G.C.E. candidates have qualified for exemption:—

Gillian M. Barker
G. L. Barker
S. C. Bazlinton
Hazel L. Collier
Anne Combeer
A. D. Crawford
D. W. S. Davies
M. Epsom
Dorothy M. Dawson
A. G. Fallowfield
T. R. L. Gould
M. D. Gross
Lynne K. Hampson
E. T. Harland
M. J. Hughes
O. L. Jeeves
D. L. Jerichower
D. I. F. Kelleher
A. C. Kelly
A. G. Kinghorn
J. K. Klosok
R. C. Knowles
Avril Little
H. U. S. McMichen
S. C. Ng Tang Fui
N. P. Norwell
D. Price
H. Robertson-Ritchie
Rosemary J. Stanley
J. C. Taylor

ROYAL COLLEGE OF PHYSICIANS OF LONDON

M.R.C.P.

A. N. Bowden
B. O. L. Duke
A. L. W. F. Eddleston
M. D. O'Brien
F. Nawab
M. C. Pearson
Mary A. Rossiter
H. D. Tunstall Pedoe

CONJOINT BOARD

D.I.H

W. R. Essen

Final L.R.C.P., M.R.C.S.

Pathology

P. D. Ashford
R. Aumeerally
N. M. Bahemuka
R. I. Bailey
N. M. Bannerman
R. J. Baxter
R. A. Billings
Philippa G. Blaxter
W. L. Brander
P. W. Briggs
J. H. W. Davies
P. M. J. Domaingue
E. Elias
Mary E. Fortnam
G. J. Gibson
R. H. Greenwood
Wendy J. Higlett
T. A. Harrison
V. J. Harvey
R. M. Ibbotson
Rowena M. F. Lawrence
*T. C. Leung
R. L. M. Newell
J. G. Payne
B. J. Rowlands
D. B. Silk
R. J. Tate
D. T. L. Turner
P. L. D. Walde
A. K. Y. Walker
J. G. Wheeler
W. J. Wiggins
R. A. Williams

Medicine

*J. T. H. Anderson
M. I. Appleby
J. S. Ashworth
R. Aumeerally
M. W. M. Bridger
*W. R. L. Clemmy
W. W. Davies
C. E. L. Freer
J. R. L. Froude
*R. P. D. Hancock
D. B. E. Jones
R. N. Jones
A. Leyshon
*A. B. Loach
C. R. McArdle
*W. D. McNicoll
*J. H. Newman
G. V. Ray
*D. J. Peters
D. B. Silk
M. A. Simpson
P. D. Wallace

Midwifery

P. D. Ashford
J. S. Ashworth
R. I. Bailey
R. J. Baxter
J. K. Bell
R. A. Billings
Philippa G. Blaxter
W. L. Brander
M. W. M. Bridger
C. B. Brown
*R. C. Bucknall
*J. R K. Butchey
Janet M. Higgs
Wendy J. Higlett
R. M. Ibbotson
R. N. Jones
Rowena M. F. Lawrence
A. Leyshon
C. R McArdle
R. L. M. Newell
W. J. Pike
G. G. Pugh
Jacqueline S. Pugh
I. T. Campbell
P. M. J. Domaingue
E. Elias
Sara J. Endean
Alex M. Falconer
Mary E. Fortnam
G. J. Gibson
P. H. R. Gill
R. H. Greenwood
T. A. Harrison
V. J. Harvey
B. J. Rowlands
D. B. Silk
M. A. Simpson
D. J. L. Turner
P. L. D. Walde
A. K. Y. Walker
Judith M. Warin
J. G. Wheeler
W. J. Wiggins
R. A. Williams
*R. H. Williams

Surgery

P. W. Briggs
*K. G. E. Brown
*G. D. Budhall
*J. R. K Butchey
J. K. Bell
*R. C. Bucknall
*E. P. Davis
W. R. Dunham
Alex M. Falconer
*A. P. Freeland
P. H. R. Gill
*A. J. Hamilton
*B. D. W. Harrison
R. A. C. Hughes
*N. Irish
*P. J. Leopard
*M. J. Lockwood
*J. N. MacLean
*R. F. J. Matthews
*B. W. R. Moore
*R. C. G. Rowe
*J. G. Pickering
*D. Stratton
*J. L. Williams
*R. H. Williams
*J. M. Worms
*J. W. Wright

*Have completed the examination

PERSONAL

HELP! Has anyone got a copy of the 1st number of the John-Miriam magazine (Nov. 1949)? Please contact Marguerite Mackinnon (née Lamarque), Mary Ward.

TWO MAN GUY'S PRACTICE offer excellent opportunity for assistant. Remuneration on a percentage basis. Write: Armitage and Lillicrap, 44, Holmhirst Road, Sheffield 8.

CHANGES OF ADDRESS

Dr. and Mrs. David G. May, "Buckland House", 27, Corkran Road, Surbiton, Surrey.

Dr. John C. Jelleyman, 14, Ranui Road, Remuera, Auckland 5, New Zealand. "Any visitors welcome."

Dr. and Mrs. F. H. A. Jago, Lambrook, La Feock, Truro, Cornwall. Feock 739.

Dr. and Mrs. Howard Mowbray, 164, Frederick Road, Hastings, Sussex. Hastings 7090, Ext. 012.

E. David Morris, F.R.C.S., M.R.C.O.G., 6, Hitherwood Drive, S.E.19. Tel: 670 5723.

Dr. and Mrs. Stuart-McHardy-Young, Department of Nuclear Medicine, Department of Radiology, Stanford Medical Center, Palo Alto, California 94304, U.S.A.

BIRTH

HARKER—On 6th July, at Cheltenham Maternity Hospital, to Sylvia (née Clarke) and Alec, a son, Alexander Robert.

We would like to remind our readers that all copy for inclusion in the Gazette must be received eight days before the publication date.

Personal notices one shilling per word (Minimum £1. 1s. 0d.)
Birth, Marriage, Death and Change of Address notices are without charge to subscribers.
Non-subscribers will pay £1. 1s. 0d. for all notices other than Personal.

GUY'S HOSPITAL GAZETTE

EDITORS D. S. ROBINS and C. B. BROWN
SPORTS CORRESPONDENT J. G. PAYNE
NURSING CORRESPONDENT E. A. MALPAS

FORTNIGHTLY TWO SHILLINGS VOLUME 81 NUMBER 2064

The opinions expressed in these columns are solely those of their authors and are not to be taken as the views of the Hospital as a whole.

PASSIM

Farewell to the College

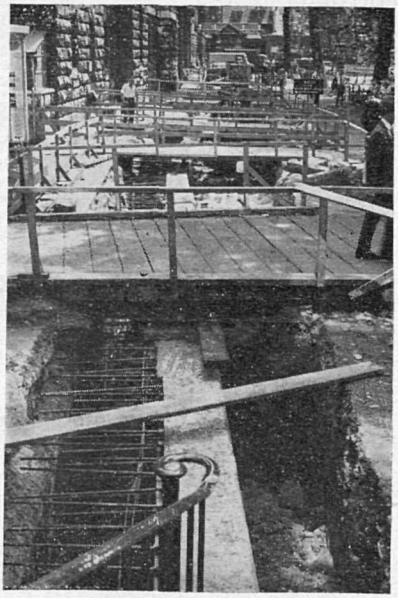
"At present the management seems to take an inhuman pleasure in making the college residents as uncomfortable as possible. It would be hard to find a parallel to such a combination of insanity and incompetence in the annals of human history."

A correspondent signed "R.I.P.", *Gazette* 1909. The building had been up for 19 years. Now, after 77 years, Gladstone's "highly creditable building of which London and this neighbourhood can have no reason whatever to be ashamed" is all but a pile of rubble. We have all been treated to the spectacle of the ball and chain. Some have even delighted in spreading the news of a change in size (precise weights given) of the all conquering ball; a new adventure suddenly sprang to life in the form of darkly-clad, stealthy ex-residents prowling the shattered corridors and rooms; various fittings left to the demolition team were snapped up by souvenir hunters (we have a wooden carved doorknob) and even a nurse, for what precise reason we do not care to think, was seen to rip a window fan from its holdings with a fascinating grimace on her face. It would even appear that outsiders were divided in their opinions about the demolition. One visitor, after leaving New Guy's House, promptly drove a new saloon car with impressive force into one of the walls, unfortunately, as was so true of the history of the College, leaving but a scratch on the building yet himself and his instrument much the worse for the encounter. It was certainly not anyone from Guy's, but a Borough resident who has persistently remained anonymous perhaps with some cause, who called in the fire brigade when fire from the demolishers' bonfire spread to the building proper, while a considerable few of those onlookers in and of the hospital were heard quietly chuckling at the irony of it all.

The deed is at last done, and now the history must be written. In this issue we make a start, tackling the subject from a number of points. The line drawings are those which appeared when the building was opened; for those who did not have the opportunity to

Ball and Chain
at the College

"The Trench" in the Park.



see how these idyllic compositions in fact compared with the actual views we recommend a brief look at the *Gazette* of 6th June, 1936! But let the material in the following pages speak for itself, and of course the correspondence columns are as open as always.

Mixture of sentiment is inevitable. The building itself was for so many years indomitable. This above all was its outstanding feature and by way of epitaph we can do no better than quote that written in 1941, when all thought that the days of the College were finally over after the bombing:

"In spite of its architectural ugliness, antiquated plumbing, and cold, draughty corridors, the College had a homely intimacy for those who lived in it, residents and students alike, and that is sadly missing today. We must thank the matron of the College for all that she did to make life more comfortable, to see that the rooms were kept airy and fresh, yet cleansed from the dirt borne by the Borough air. The unfailing courtesy and efficiency of the College porters and the convenience of a restaurant which did not insist upon rigid hours for those who perhaps had been called up several times during the night, or perhaps had just overslept, are now but happy memories to be looked back on until the hospital has again a college of its own."

Dr. L. Forman

This week sees the departure of Dr. L. Forman from the consulting staff of the hospital. We would like to wish him a most enjoyable and productive retirement, now that his extra year with us is over. We shall be publishing an Appreciation shortly.

We would particularly like to record our appreciation to Mr. Peter Davenport, who undertook the bulk of the task in researching amongst the 77 years of fortnightly *Gazettes* to provide much of the background material for this issue.

Prints of the photographs on pages 474–476 may be obtained from Mr. P. Stevenson, of Stevenson's hardware shop at 99, Borough High Street, S.E.1, who took the pictures shortly before the demolition work began on the College. Other photographs are by kindness of Mr. J. Rytina, head of the Medical Illustration Department.

GUY'S DIARY

We offer our congratulations to :—

Professor W. E. Herbert, Professor of Dental Surgery, who has had the title of Emeritus Professor conferred upon him.

Mr. F. G. Ellis, on his appointment as Consultant Surgeon to the Royal Northern Hospital, London, in addition to his post at Guy's.

Mr. P. J. Stiles, on his appointment as Consultant Orthopaedic Surgeon to the Guildford and Godalming Group of Hospitals.

Dr. R. H. Robinson, on his appointment as Consultant Anaesthetist to the Harlow Group of Hospitals.

The following who have been recognised as teachers by the University of London :

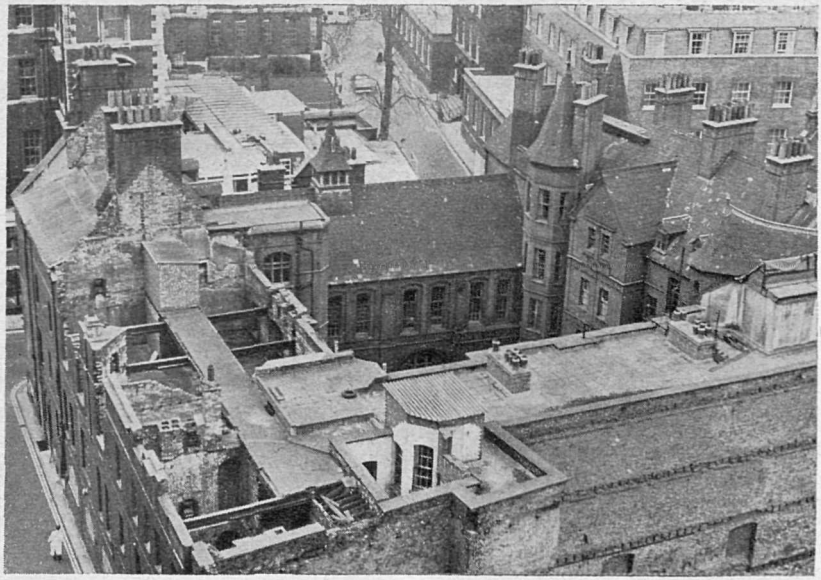
L. F. W. Salmon as a teacher of Otorhinolaryngology.
H. M. Saxton as a teacher of Radiology.
R. J. Vale as a teacher of Anaesthetics.

SEPT.

12th Tu. 8.00 Music Circle. Bernard Miles, East Wing.

OBITER DICTUM :

Cardiac Patient: "My God I've stopped fibrillating. These Sonic Booms make me jump."



College after Second World War.

College Demolition—New Guy's House in background.

FAREWELL TO THE COLLEGE

by

P. M. F. BISHOP

The Conception of the College Followed by a 50-year Gestation Period

In 1839, in his introductory lecture to students, Thomas Addison announced the intention of the Treasurer, Mr. Harrison, "to erect a suitable building for the lodgement of students in which each individual should enjoy the privileges and advantages afforded in these particulars by Oxford and Cambridge".

The scheme misfired for a very familiar reason—lack of money. Hospital funds could not be used to build students' lodgings and the newly-formed Medical School had inadequate funds for such a purpose. It is thought that the Treasurer might have been hoping to find a donor among the Governors. If so he was disappointed.

The next time we hear of the scheme is in 1877 when we are told that a sub-committee had been appointed to enquire into the possibility of providing the building and that the Charity Commissioners had agreed to £10,000 being raised on the Hospital Estates for the purpose, provided that the principle and interest were repaid within 30 years. Furthermore, the Equitable Insurance had offered to make the loan at 4 per cent per annum. Again the School whose only income was derived from students' fees could not afford such large sums and once more the scheme was reluctantly set aside.

By 1885 however the need for a residential college became urgent for a new reason and one that this time affected the Hospital rather than the School, namely the increasing number of resident house-officers. There was a Dresser's House in the Front Quad at that time but its rooms were now full to overflowing. Three years later another sub-committee reported on the number and character of the house appointments required. At that time there was only one resident house-surgeon who in addition to his other duties had to give anaesthetics and attend inquests. In fact his dressers carried out many of the duties assigned in other hospitals to a house-surgeon. There were only two house-physicians each trying to cope with two physicians who not infrequently did ward rounds at the same time. The sub-committee recommended that there should be four house-physicians, two assistant house-physicians (O.P.Os.), four house-

surgeons and two resident obstetricians, and that they should all, except the O.P.Os., be accommodated in the Hospital. This made the building of a residential College not only desirable but urgently essential.

Debentures were issued, secured as a first charge on the Medical School Fund, "in the disposal of which the Governors have exercised undisputed control, since the foundation of the School in 1825". The Hospital would pay £650 annually into the College account for the board and lodging of ten resident house officers.

There was already a gymnasium, of sorts, fitted up temporarily in an empty ward in Hunt's House, and another empty ward had been allocated as a "Students' Club". These activities could now be transferred to the accommodation in the new building and the sub-committee recommended that a dining hall and other rooms for the use of the Students' Club should be provided.

The Birth of the College

And so, 50 years after the scheme was conceived, the College was built in 1890 and opened by Mr. Gladstone, the Senior Governor of the Hospital, in a speech that was reported *verbatim* in the *Gazette* and which took me 45 minutes to read. In it, among other remarks, he congratulated the medical profession on being entirely self-supporting and making no demands on the public purse! The gymnasium was transferred from the empty ward in Hunt's House to an excavation under the central courtyard of the College and the expense defrayed by the senior physician, Dr. Pavy.

For a time the College was the pride and joy of the Hospital and School. It was the first Residential Hostel to be built on the premises of any of the London teaching hospitals. In fact, the next hospital to allocate accommodation of a residential and common room nature was Bart's in 1912, as part of the Out-patients' Block. Here 25 residents and 25 non-residents were provided for. Separate accommodation was not set up by the other teaching hospitals until between 1926 and 1938.

The Wardens of the College

The first Warden was Dr. (later Sir) Cooper Perry who, since 1888, had been Dean of the Medical School and had therefore had much to do with the fulfilment at last of the 50 years' intention to build a College and with the detailed plans for its erection. He remained Warden until he succeeded Dr. Steele as Superintendent in 1893; after his retirement from that post he became first Principal and later Vice-Chancellor of London University. Perry was a great administrator and one of the outstanding personalities of the time. From 1893 to 1902 the Warden was Mr. L. A. ("John") Dunn, a bachelor and immensely popular with the students and house officers, most of whom he called by their Christian names—an unusual practice in those days.

In 1902, when John Dunn reluctantly retired from the College, he was succeeded by Mr. (later Sir Herbert) Eason, a great admirer and a protégé of Sir Cooper Perry and one who followed exactly in his footsteps, serving as Dean from 1907 to 1913, Superintendent from 1930 to 1937 when he became Principal and Vice-Chancellor of London University and finally President of the G.M.C. Like Perry, he was a great administrator and an outstanding personality. These first three Wardens had therefore the administrative knowledge, the authority and—in the case of John Dunn at any rate—the personal popularity to establish the new venture firmly. The enterprise was soon running smoothly to the contentment of all concerned.

Subsequent Wardens were Mr. W. M. Mollison (1906–1912), Mr. Lancelot Bromley (1912–1920), Dr. John Ryle (1920–1923), Sir John Conybeare (1923–1938), P.M.F.B. (1938–1947) and Dr. Charles Baker (1947–1967). Perhaps it is appropriate, and certainly very pleasing, that the last of the Wardens should marry the last of the Matrons (Miss Jean Bailey).

The Decline but not Fall of the College

The *Gazette* of March, 1890, reporting the opening by Mr. Gladstone, remarks: "the large rooms of the College, the smoking room and the dining hall were very generally admired and great interest was shown in the kitchen and the departments pertaining thereto. The sitting rooms were visited and were considered very pretty. . . ." This was certainly the heyday of the College but time and chronic lack of money took their toll and in due course isolated complaints began to appear—the smoking room is too small (1898); the food is of bad quality (1905); and so on—until the adverse criticism became more constant. In 1920 there seems to have been clear evidence of long-standing dissatisfaction with the amenities, and renovations were undertaken, but they were limited by lack of funds. The restlessness continued and reached a crescendo in 1936 when the *Gazette* was filled with letters and Passims demanding a new College. Most of the other London Teaching Hospitals were building or had recently built residential premises and our own College, now nearly 50 years old, seemed very dingy in comparison. The most important 1936 protest came from more than a quarter of the student body, including the present Dean, in a letter to the *Gazette* the main theme of which was "Without a doubt the whole place should be rebuilt".

But how? Passim of February 1st, 1936, put the position very clearly. The College, for which the Medical School was financially liable, was leased from the Hospital at a rent of £900 per annum and the lease was due to expire in 1942. The College's annual income was derived from rent paid by those students who resided there (28 in 1938), £1,000 paid by the Hospital to cover the maintenance of their resident staff (32 in 1938), £200 paid by the Club's Union Council for the use of the restaurant and smoking rooms and a £200 government grant paid by the University of London. On this income the College was running at a loss of £200 per annum and this was certainly not due to mis-management. Upkeep and repairs cost more each year the College got older, and porters' and servants' wages had to be paid.

It was estimated at that time that the cost of rebuilding would be £60,000 and it was thought that this would provide all, or most, of the amenities that the student body were clamouring for. But who could provide the £60,000? Certainly not the College itself, which was rapidly getting more and more in debt. Not the Medical School, which was in the process of building a new Pathology Block and increasing the number of its teaching staff. And finally not the Hospital, even if it had the funds, which it didn't, because the Charity Commissioners would not allow it to do so. The only possibility was to find a donor, or to establish a fund to which generous Old Guy's men and others might subscribe. Indeed, when I became Warden I tried very hard to raise such a fund, but with the Second World War staring us in the face the time was not propitious.

In the meantime all we could manage was running repairs and inadequate improvement. For instance, at that time I presented a memorandum on the subject to the School Council as the result of which we received £300 to pay for alterations that were considered immediately essential.

The Second World War and the College

Then came the war. And our attitude changed—temporarily. Those who were responsible for running the hospital, sometimes as a casualty clearing station, at other times in a more comprehensive attempt to maintain the functions of a teaching hospital, depending on the intensity of enemy action, used the College, Sophie's Hostel and Nuffield House to varying extents to house not only the consultant staff and house officers but also the students, usually about 40, upon whom I relied heavily to maintain the hospital services and deal with the utmost emergencies that might—and indeed did—arise as the result of enemy bombardment.

This was no time to grumble about life in the College, and perhaps in some ways this was its "finest hour". Nevertheless some of us may have secretly hoped that Hitler might do what we had failed to achieve—to destroy the College and make it essential to build a new one. He very nearly succeeded on December 29th, 1941, when he completely surrounded the hospital by fire and burned down a considerable portion of the College. At that time I wrote an article for the *Gazette*, entitled "Farewell to the College", in which I said that "in view of the damage sustained by the College in the big London fire raid it has been decided to close it, and it is unlikely ever to be used again."

But subsequent events and, again, chronic shortage of money proved me to be wrong. The College was soon patched up and at the end of the war it and the much despised Sophie's Hostel were once more providing residential accommodation.

Plans for a New College

Not that we were not still making plans for a new College. Mr. Blaikley, Mr. Wass and I spent many evenings, stimulated by the explosion of doodle-bugs and rockets—and black coffee—devising the

details of a new College, to occupy the space between the present College and the then site of the Miller by the entrance to the out-patient department. It would have been an E-shaped building, the residential portion consisting of the L-shaped upper portion of the E; the recreational portion would be contained in the middle stroke of the E (and would consist of dining room, common rooms, committee rooms, billiards room and a swimming bath); and the lower L-shaped portion would be devoted to residential quarters for relatives of seriously ill patients, for single or married registrars, and pieds-à-terre for consultant staff. We suggested that there should be a spacious underground garage, and we reckoned that at immediate post-war prices it would cost a quarter of a million pounds.

The Phoenix

So ended the war—and the College had grown into a rather ugly phoenix, that must be preserved—but not at all cost. My wife and I set about refurnishing the remnants of the College as best we could before we left in 1947, when Dr. Baker took over and Miss Jean Bailey continued cheerfully to provide as comfortable accommodation as possible to a post-war co-educational group of residents and to a certain number of male students.

The East Wing

In the meantime, plans were put in hand to rebuild the East Wing of the front quadrangle, the site of the old Treasurer's (later the Superintendent's) house, the Court Room and the Counting House, completely destroyed by Hitler, but partly rebuilt later to provide beds for gynaecological patients—Sarah Swift Ward. In the course of the rebuilding of (Old as opposed to New) Guy's House the East Wing was restored in its original 18th century design to match the West Wing of the front quadrangle and now provides bed-sitting rooms for the resident house officers as well as dining rooms, common rooms and recreation rooms for the residents and students. Nevertheless the College still had its uses. The Warden lived on there like the captain of a sinking ship and it still provided lodging for resident students. But now at last it is being demolished to make way for the new Tower Block.

Farewell the College—for the second time

And so—farewell to the College—for the second time. For 50 years Guy's strove to build it but couldn't do so—for lack of money. For 50 years its existence was first praised, then tolerated and finally considered intolerable. For the last 30 years everyone has tried to destroy it—the residents who lived in it, the students who fed and tried to relax in it, and finally Hitler, whom I thought had succeeded. But I was wrong; it rose again to provide its dingy board and lodging for another 20 years to a disillusioned post-war generation.

This is a sordid story, and for one reason only—chronic lack of money. Throughout its whole history the College was wanted, the fundamental principle of its existence gratefully appreciated, its gallant

resistance to enemy action proudly acknowledged, and its surprising resurrection tolerated as an unavoidable necessity.

Yet those who have known it, as I did for nearly 20 years (1928–1947), must have an affection for it which is quite different from the affection one has for anywhere else one lived. The bed that folded up into the wall and was so troublesome to let down after a residents' dinner; the primitive showers, baths and shaving accommodation in the basement where one reluctantly made one's first attempt at conversation in the mornings; the porter's call from the quad—Shipcott's voice unmistakable and unforgettable—"Mr. Clark, wanted in Naaman"; the extern's room and its panels, unique examples of orthodox obstetric pornography, where one sat at all hours of night and day, playing poker, drinking beer or black coffee, waiting for the next call on bicycle to Weston Street or Peabody Buildings; the Pavy gymnasium, that incongruous emblem of athleticism and purveyor of the smell of sweat that assailed one as one sat working at the open window of one's bed-sitting room; that breath-takingly ugly dining hall with its chronic memories of badly cooked and inadequately served food; the Warden's House and shades of Cony with whom I lived there before I married and took over the House myself; the enormous bath in the narrow bathroom so that one had to climb in over the back-end; the cage we put outside the staircase window in which we deposited our first-born so that he could get some sun. Nostalgia is a curious sentimental yearning for the past not because the past was celestial but because it was a characteristic part of one's life. Home, school, Guy's—all are memories, not necessarily always pleasant, but recalling events, atmospheres, friendships indelibly stamped on one's personality, and of the memories of Guy's the College may be strongest for one reason or another in many people's minds.

Residential Accommodation for Students

What is sad, and indeed I think may be serious, is that with all this rebuilding Guy's is certainly not encouraging its students to live, that is to stay and spend their nights, at the hospital. Sophie's Hostel is gone, the College is gone, St. Christopher's is some distance away and the East Wing has no residential accommodation for students. It is, I think, very important that every medical student should reside for a reasonable period of time in the hospital and absorb its atmosphere. Commuting students can become similar in attitude to 9—6 office-wallahs. The spirit of Guy's is just as important, perhaps more important now, as it was in the days of "King" Harrison, Astley Cooper, Addison, Bright, Hodgkin and Wilks, or Hurst, Ryle, Steward, Rowlands, Marshall, Slessinger and Cony. Let us not forget this and let us strive to see that our residential accommodation enables, in the words of Addison, "each individual to enjoy the privileges and advantages afforded by Oxford and Cambridge"—namely to live "in College" for at least some part of his student life.

Acknowledgment. I am grateful to the Editor for allowing me to peruse the appropriate copies of old *Gazettes* and I have drawn heavily on my copy of Wilks and Bettany's *Biographical History of Guy's Hospital*, and of H. C. Cameron's *Mr. Guy's Hospital*.

FOOD AND THE COLLEGE

"We are once again faced with a recrudescence of this old, old problem." Passim, July 8, 1922.

Of the many items that drove the protesting voices of previous and contemporary residents in the College, the sensitivity of the palate was the one which far in excess of the others cried out in anguish. Indeed the initial arrangements for eating augered anything but such a future dissatisfaction :

> "The dining hall forms the west side of the quadrangle. It is on the first floor and looks over the Hospital grounds. It is a very handsome room, measuring 21 ft. 6 ins. by 70 ft., and is capable of seating 120 persons at dinner. It has an open pitch-pine roof, with a central flache, and is lighted by side gas jets. Two Sharlands grates afford a due supply of warmth both by means of their fires, and by causing the circulation of heated fresh air through pipes over each grate. When in general use the table d'hôte will be arranged down the centre, and there will be small side tables for light refreshment."

Within a few years, however, it began :

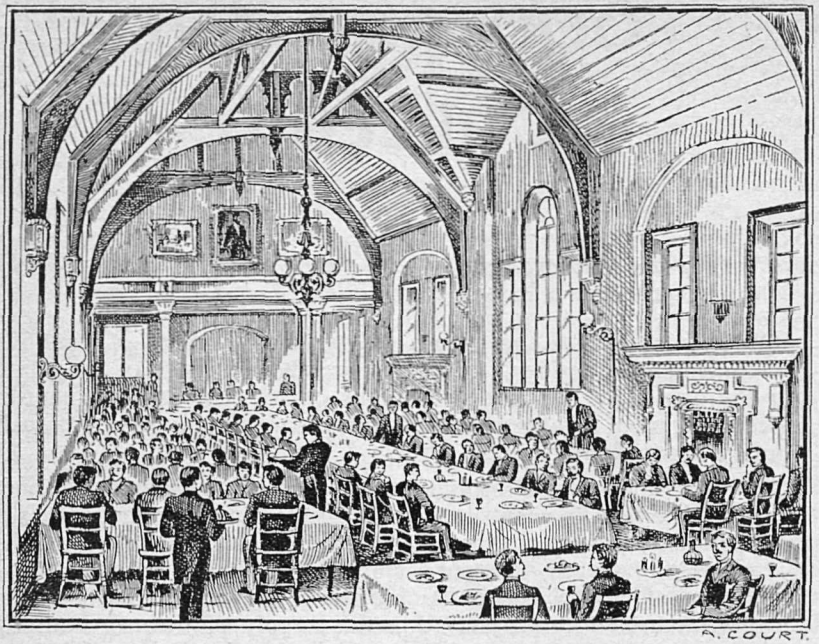
> "The catering in the college dining hall is in the main as unsatisfactory as it ever was, and more so; in addition to this, there are those who affirm, with some truth, that it is getting worse."

Which is quite some beginning.

> "To get a dish that is palatable (and residents have not jaded appetites) is an event of some rarity, while to get a dish that is hot is almost unknown."

Matters did not stop at what was, and is often a problem, i.e. the provision of varied hot meals to large numbers. An irate correspondent in 1905 wrote :

> "I am taking this opportunity of calling your attention to another item of the catering which is badly in need of reform. I refer to the liquid which is served to us at the price of two-pence per cup, and which is by courtesy called coffee—at least it is given to us when we ask for coffee. . . . Perhaps Messrs. Lyons would undertake to give our cook a few lessons in coffee making. It is really so simple, and he could learn in half an hour. A little trouble and care is necessary, however, which is, of course, a drawback."



The Dining Hall—*1890 impression.*

Many such outbursts were apparently erupting at the time and for some time afterwards, so much so that even Passim might have appeared to be inclined to tone down the matter, offering by way of excuse however : (1913)

> "Most men living in the College—and these are naturally the chief complainants—are not in general ' fit,' and, as we all know, one of the first and chief symptoms of poor health is capriciousness and loss of appetite."

Carefully avoiding any attempt to offer a suggestion as to the aetiology of this lack of "fitness". That the residents suffered from this unnamed disease in increasing numbers and to more overt degrees was evident a few years later when in 1922 the sign of capriciousness became so bothersome to an onlooker that he was compelled to write to the *Gazette*:

> "May I, through your columns, voice a protest against the abominable behaviour of residents at dinner every evening in the college dining room? I should hate to suggest that any traditional practice at Guy's should be abolished, but this childish exhibition of bread throwing has been but recently started and is probably encouraged by an occasional sickly grin from the audience. We have now to swallow our stale meals to the accompaniment of a demoniacal orgy of plate smashing and table turning. The Residents are, quite rightly, privileged people and deserve their nightly amusement, but I feel sure the majority of

others who live at the College would be quite willing to subscribe towards the construction of a sound-proof dining-strong-room, where they could nightly hold wassail, and dinner still remain for us a pleasant hour.

"Postscript: The bread wasted by the Residents might be converted to a much more worthy use as poultices for the Front Surgery."

At this time the catering was provided through contract, strangely enough by the Aerated Bread Company. The long autumn of discontent with the menu and environment culminated in a winter of meditation and planning which resulted in the rescinding of the agreement with the A.B.C. and the birth of the College Catering Company into action in February 1927. The idea of a private company founded by Guy's men—share capital rapidly and almost completely subscribed to by members of Guy's Staff—was obviously an attractive one and optimism was unbounded, especially as the bulk of the profits were to be ploughed back in the form of reduced prices and improvements to the food. After a year, Passim was almost euphoric in its references to the new catering, allowing to be reported however that in the dining room :

". . . Gaelic nomenclature and high flavouring are on occasions but poor compensation for overcooking and inadequate quantity."

The conditions under the new management must, however, have been some considerable improvement for there was a lapse of printed criticism lasting nine years, during which there was in fact a further item of praise :

"No longer shall we be obliged to leave the breakfast table to wash away the ravages of the spurting grapefruit; no longer on our first appearance on the wards will the observant sister be able to diagnose the morning kipper by the absence of facial egg, for a new era of comfort has dawned and residents in the College are now supplied with table napkins."

Which was a feature indeed, considering the total absence of such a "comfort" in our present formica dining rooms.

All was not rosy, however, towards the end of the honeymoon; that is to say, with regard to the satisfaction of residents, for while the following extract from Passim is not complimentary it reveals an almost idyllic existence where the morning air was apparently rarely tasted by these supposedly hard-working men. In addition, a certain fruit had become the symbol of the residents' position in life, and there had obviously been some fervent action and words from these "Grapefruit People" when the sacred object was not at hand under the right conditions. Thus on the subject of breakfast :

"It is, however, quite impossible, even after years in the College, to know how to be served with a boiled egg at 1 p.m. in the

Dining Room. In recent times many of the quainter customs of the Catering Company have been abandoned. We are now no longer treated to the spectacle of residents, in protest against having to pay for grapefruit, throwing a daily plate of sausages out of the window or hoarding buckets of eggs, garnered from the breakfast table, in their rooms.

"One of the more striking anomalies that remain still concerns the grapefruit. Half of one of these delicacies may be supplied to the take-in dresser; if the other half is needed it must be paid for. The dresser is, however, at liberty to order two or three shillings' worth of sausages and eggs, though all he may want for breakfast is a whole grapefruit.

"The choice of breakfast for those who want it after 11.30 (*sic*) requires considerable experience if the day is not to be started on *creme parmentière* and roast beef. One may, for instance, have coffee, but not toast, unless poached eggs are on it, and then only if spaghetti and poached eggs are on the menu. On Sundays, fried eggs may be obtained, but not on fried bread, only on fried potatoes."

Came 1936 and the love affair was over. It began with a letter by "Carfax" in January, which read like the closing remarks of the prosecuting counsel in an unsavoury divorce suit. Passim exhorted "Let's stir 'em up," remarking on the way

"The appearance and architecture of the semi-basement cafeteria, which we have already described as being in the neo-lavatorial style, will enable the newcomer intimately to understand why such a breeding ground of consumption should be referred to as the 'Spit'."

Shortly afterwards a petition was signed by 227 students (more than a quarter of the student body and including the present Dean), calling for the college to be rebuilt. Another letter suggested that :

"The only argument in favour of the College is that being so uncomfortable, it is more comforting to work in the Hospital."

By June, this campaign was obviously beginning to have some effect, and it is suggested to us that it apparently was producing some considerable anxiety in the ranks of the target :

"It is said that it (the College Catering Company) has insured up to £10,000 against the death of any of its patrons through food poisoning."

One letter amongst the many published that year stood up in favour of the "Spit", though the justification was somewhat dubious :

"In my day, before the War, the South African War, we thought as little as you and your contemporaries of the 'Spit'. It drove us out of the place at nights, and during the day drove us

into the wards, and was in my opinion a great influence for good. Throughout the Empire, Guy's men are known for their clinical acumen and practical ability. The part played by the 'Spit' in producing this type (who never neglects to do his R.E.) is too little realized."

But there was some action and in the summer vacation the Spit was redecorated.

"The death throes of that horrible old room started on a wet, grey day last week, when we found the men hard at work digging up the floor with shovels. A curious aroma reached our nostrils as the pieces of parquet were uprooted: cockroaches, and sugar bun, tar and black beetles' blood. Was there ever such a smell, or ever such a room?"

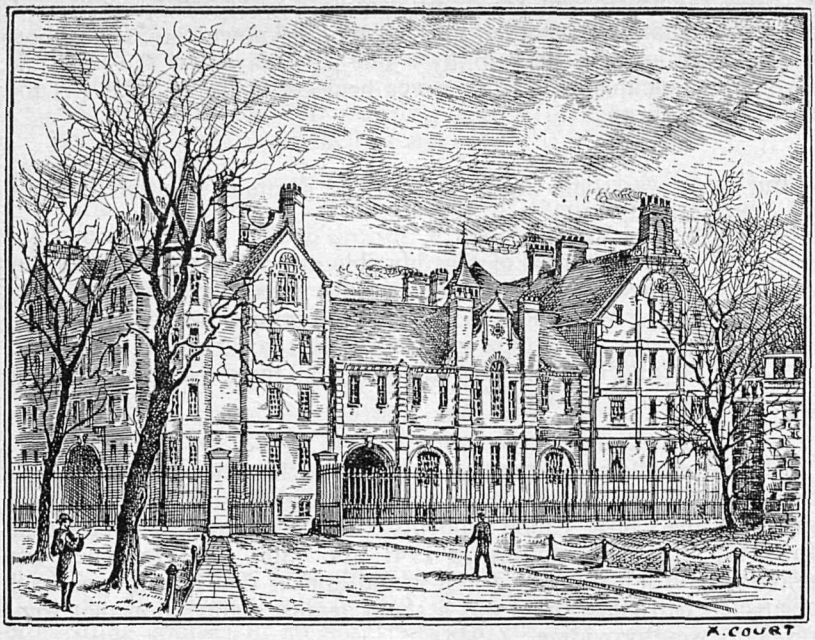
Thereafter all was quiet again. The food became more acceptable to some and the profits were sizeable enough to make considerable grants to the Clubs' Union Students' Clubs and to the College itself. In 1947, after the bombing in 1941, the "Spit" was reopened and praised. But not for long, for it would appear that having won back a satisfied patronage there was a stand against competition that some residents were providing: (1948)

"Have you ever tried to live solely on the food provided by the 'Spit'? Those of us who are living in the hostels have, and we find from experience, that it is impossible to do so. The food which is now provided is inadequate in amount and has, of necessity, been supplemented by cooking in the hostels. The final insult has now been added, for this is no longer permitted; even the boiling of an egg is illegal."

By 1950, the N.H.S. had had two years' experience, and while so many things about the hospital changed, the old subject was there as ever:

"To face the same fried potatoes and shrivelled tomatoes first thing every morning, or to be regimented into dinner before half-past seven every night is both thoughtless and unreasonable to a point of insult. . . .

"So far as details are concerned, hot plates *are* an advantage for hot foods. Coffee making admittedly is an art, but reasonable coffee can be prepared, given a little care. Indifferent coffee is quite unpalatable. Clean tables, daintily laid, serve to enhance appetite. Broken-spouted teapots and coffee pots crying out for catheterization are no aid to the preservation of spotless table cloths. Cabbage may possess various dietary features, but not when it is stewed to pulp. Salads are not compounded simply by adorning three limp lettuce leaves with two half tomatoes



Front View of College—1890 impression.

and a few chunks of smoky beetroot. Finally sausages, although by recent edict boasting an increased content of meat, are like so many dogs, languishing under a bad name."

Thereafter, however, these and many other things remained unchanged, and indeed some of the above remarks are pertinent today in the East Wing. In fact, when the Spit and Dining Room moved to the East Wing of Guy's House in 1964, the accommodation was magnificently improved, so much so that it is now difficult to imagine that the eating squalor in the College was tolerated as well as it was. The food itself, however, changed little. What did continually change were the names applied to the same food, and on occasion the ways in which the same food was served up under different camouflage for a number of meals after its first appearance. Perhaps it was the sense of achivement in obtaining new cutlery, crockery and environment that kept comments on the food to a minimum, although equally likely was the touch of unconscious humour that was provided by the veritable French thesaurus that must have been the chef's prize possession. Thus it was that the final major criticism came to be one that reflected the gay acceptance of the fare so that there was nothing left to criticise but the nomenclature : (1962)

"' Tomato soup,' it said. It was a great relief. After a week of continental soups, we had awaited, with dreary expectancy, another fancy College menu beginning with ' Capelleti nel brodo di Cappone ' or ' Bouillabaisse du pays de cornouailles".

"It has long been the policy of the College Catering Company to write its menus in foreign languages. In general, their customers can indulge this whim without much hardship, as there is usually someone on hand to make the necessary translation ; but with the soup course it causes disappointment and mocks salivation. One goes to the dining room, eager for nourishment and conversation and finds that, for example, Crême St. Germain is the soup for the day. . . .

"Another day it might be le Potage Garbure. Our acquaintance with expensive West-end night-spots, and a few moments reading the cookery books in Smith's bookstall, has led us to the knowledge that "La Garbure is a savoury and solid soup produced with different variations in Gascony, Béarn, and the Basque country, a dense concoction of fresh vegetables in season, pickled pork, ham, sausages and haricot beans, transformed into a memorable experience by the addition of comfits of various kinds, preserves of meats and poultry.' A soup, in fact, that is so individual, so substantial, that it should be ladled out in public from a giant tureen, and not, as one book remarks, served furtively from a saucepan.

"Soup à la bonne femme, another C.C.C. plat du jour, is a more suave and sophisticated potage, although its name does conjure up the picture of a plump and genial Frenchwoman serving mighty platefuls of farmhouse pot-au-feu to a group of smiling peasants. Apparently, 'Keffner maintained that soup à la bonne femme was an attempt to paint the character of a good woman, a culinary portrait uniting two principal concepts of womanhood, symbolized by the malleability of cream and the acidity of sorrel.'

"We could go on endlessly and go on to describe Minestra Milenaise, Crême Portugaise, Crême Solferino and a host of other soups which are served to us having only a ghostly semblance of their originals. However, we may simply plead that pretentious foreign names be omitted from our menus, at least from the soup course. If it is really thought that such simple descriptions as tomato soup, chicken soup, pea soup, are inadequate, or, if further elaboration is necessary in order to raise the tone of the place then, we suppose, cream of tomato, cream of chicken, cream of pea, would be acceptable to most of the customers. But please, whatever else, let us have it in English."

In summary, the barrage of criticism levelled at the College facilities issued overwhelmingly and almost alarmingly from an army which above all others marched on its stomach.

D.S.R.

AN EPITAPH

Oh folks, 'tis sad, 'tis very sad
The College is coming down,
It's stood for years upon that spot,
A building of renown.

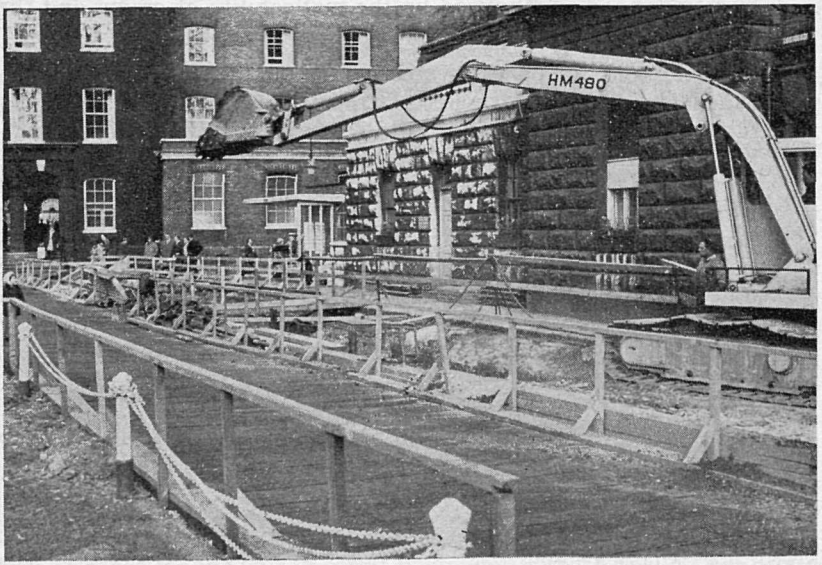
If walls could speak such tales 'twould tell
And maybe folks would frown,
But some would laugh at what they heard
Of the building of renown.

The years have come, the years have gone,
An honour it's been to Guy's
To have the building standing there.
Tradition never dies.

But now has come the time to lose
This building of renown.
As heights increase and sky grows less
In fine old London Town.

ROSEMARY CLIFTON-CRICK

CHANGING FACE OF GUY'S



A View from the Park.

New Guy's House with College in right foreground.

Guy's House.

A KIND OF LIVING

The year 1938 is probably better known as the time of the "gathering storm"—but in retrospect the term may be equally applied to the residential row as to the then approaching hostilities.

One correspondent made his views on the state of the College accommodation harshly clear to readers of the *Gazette* in the following outburst:

> "On two separate occasions in the past year I have been consulted by my patients as to which hospital their sons should enter. On my suggesting Guy's, the reply is, 'But the Residents' living quarters are so bad'.
>
> "I visited the College recently and was horrified to find that, to add to the squalor and discomfort, a particularly pernicious type of gas stove has been installed in the residents' rooms, calculated to give out a high percentage of carbon monoxide. On talking to one of the residents I found that by lighting this fire first thing in the morning and leaving it on till late at night, keeping the windows tightly closed, a warm, soporific atmosphere can be produced, which renders one slightly less conscious of one's discomforts."

The correspondent concludes that he must regretfully "abandon recommending any parent, interested in the welfare of his son, to enter him at Guy's".

However, in 1928 it would appear from a comment in Passim that at least the sporting activities of the inmates of this Victorian home from home were, in some cases, of an interesting nature.

> "We understand that the royal and ancient game of golf has been rediscovered—in the College, at least. Daily we are greeted by the sight of suspiciously long and irregular packages in the lodge. Nightly our meditations are disturbed by a whirring through the air closely followed by a tinkle of broken glass issuing from the Pavy Gymnasium. It is even rumoured that a 9-hole course is being laid down in the heart of Bermondsey. We presume that there will be a local rule to deal with balls lost in passing vehicles. During meals words such as 'slice' and 'stymie' fill the air, while the word 'bunker' occurs as frequently as it appears to occur on the average golf course."

These antics merely offset the day-to-day monastic-like existence that is depicted in this the following excerpt, 1936, from Passim—that watchkeeper of the students' interests:

> "We have remarked before on the absence of heating, the inadequacy of the four baths in the basement, the bleakness of

the stone corridors; one has only to make mention of the Heath Robinson beds, the darkness necessitating in many rooms the continuous use of artificial light (fortunately now electric), and the presence of LICE to complete a picture of insanitary wretchedness. We have more than once found coleoptera, and this made us wonder whether it was not, perhaps, on this account that in some of the rooms the beds are protected from any but aerial attack by these monsters through the ingenious method of having them folded up behind the bookcase."

This sorry plight of our predecessors, bad as it may seem, was nevertheless suffered under a fear many of us would hardly believe unless it was recorded by Passim two years previous to the above observations.

"How often have moans of the sad plight of those condemned to exist in the College served to fill this exacting space! Nevertheless, we feel that the recent silting up of the pipes and the consequent complete failure of the hot-water system justifies more than the habitual grumbles, and almost justified the stream of blasphemy that rent the air, from earliest R.O. to latest H.P., during the length of that first sad morning. Unless content to match the mediaeval squalor of their surroundings with unwashed bodies or emulate the lesser-bearded highbrows of Bloomsbury with unshaven faces, the Residents are forced to seek the hospitality of the wards or dare the heights of the Surgeons' Room."

In 1936 the general smouldering and stirring of those battered babes—the residents—was given the necessary oxygen to start what became a fiery holocaust of dissatisfaction—the Olympic flame was held by "Carfax", the correspondent with these words:—

"In the course of a recent visit to some of my old haunts at Guy's, I had occasion to go across to the College for tea. It would be no exaggeration to say that I was appalled at the conditions I found there.

"The staircase, almost impassable because of the accommodation of bags, coats and hats, clearly pointed to deficient cloak-room accommodation. The smoke-room in the basement, crowded, untidy, dingy, dirty and neglected looking, is one of the most uncomfortable places I've seen for a long time.

"The present accommodation is obviously inadequate, but that is not the excuse whatever for the filthy state in which the place is kept.

"An organism reacts to its environment, and it is difficult to assess the damage which is being done to the morale of students who, by force of circumstances, may be compelled to spend much of their time under such conditions. What opportunity can it possibly offer for pleasant and comfortable intercourse with their fellows?

"This is the twentieth century, when an act was passed called 'The Slum Clearance Act'. Is it fair or reasonable that lads who presumably have been recently brought up should be compelled to use a place which definitely *is* uncomfortable and *looks* insanitary?

"It is admitted that there are probably difficulties in the way of the rebuilding which is urgently necessary. That, however, is no excuse for the present condition of the place. It is enough to bring a blush of shame to the cheek of every old Guy's man."

A blush indeed, Sir!

A veritable conflagration of protests, demands and damnations succeeded this spark. One letter was signed by 227 students, including the present Dean, another unveiled a rumour that the borough building inspector condemned the College four years previously in 1932. "Carfax" sent another salvo with the suggestion that a new College be built as a memorial to King George V, using the milk-churn as a receptacle in the collection of half-crowns to help defray the costs!

Throughout '36 and '37 the pitiful comments of personal misery suffered continued. It was not until 1938 that some attempt to consolidate opinion was made. A questionnaire on "A New College" was sent out and was shortly followed by an excellent comparative table drawn up by the then Warden, Dr. Bishop, of the residential accommodation at the other London teaching hospitals. Guy's compared, as was expected, somewhat unfavourably to say the least.

The War came and most ideas were shelved, and then in 1941 it happened—the College was struck by one of the many bombs that fell that fateful day. All but one wing of the College was gutted and even this wing lost its roof. "Whatever opinions about the adequacy of the College we might have held, to see the College so wantonly destroyed was indeed a tragic sight." Thus spake Passim.

But a few weeks' later the Warden, Dr. Bishop, wrote these opening words in an article entitled "Farewell to the College".

"In view of the damage sustained by the College in the big London Fire Raid it has been decided to close it, and it is very unlikely ever to be used again."

It would seem that the Devil had done his one and only good deed, for in that same article the opinion was expressed that there was no other alternative left now to the Governors but to build a new College.

The War ended and lo and behold the College was patched-up and reopened with the comment from one wise-cracker that it is "good for another 50 years" and that "we were getting spineless before the War" to complain.

So then with time the grouses re-appeared in the columns of the *Gazette;* palliative repairs were made, walls shored up and bright paint splashed on and with typical British masochism things were muddled through.

C.B.B.

THE EXTERNS' ROOM

by

J. B. BLAIKLEY

With the demolition of the College there finally disappears one of the well-known features of Guy's for many years, though latterly it had become the Residents' Bar until the House Officers moved into New Guy's House. I refer to the Externs' Room, that small sanctum opening off the passage as one entered the College. When the room came into existence, I am not sure, but certainly for many generations it was the centre from which the Guy's District operated.

Until 1926 there were only a very few obstetric beds and many thousands of mothers were looked after by Guy's Externs, students who had completed their first three months as Obstetric Dresser, who attended them in their own homes with the help of a Sarah Gamp or handy-woman.

I should add that to the west of Guy's the midwives also had a small District.

The externs who were responsible to the Extern Charity, the senior of three Obstetric House Officers, lived in the Externs' Room and there wrote their records, discussed their problems with one another and with the Extern Charity, and in the evening entertained a few friends to cocoa and biscuits.

It was a privilege to be invited to the room and intruders were not welcome, and in fact, were made to understand this, often in no uncertain manner. I well remember the late Dr. Marston telling me how he and his fellow extern decided to put the pressure on a thick-skinned individual who nightly appeared and drank liberally of the cocoa and anything else available; on the first night they added a grain of Calomel to the drink, and increased it by a grain each night until he had five grains. The man turned up again next evening to announce how well he felt and that at last his bowels were acting regularly! They gave up for fear of producing mercurial poisoning. Incidentally, in the years following the first world war there was a great boom in the birth rate and Dr. Marston and his colleague each delivered more than 90 mothers.

As a rule there were three or four externs on duty for a month at a time, and each had to deliver at least 20 mothers. The late Mr. Philip Turner, who retired well before the war, is reputed to have left all his deliveries until the last 48 hours of the appointment, and during this time he had all twenty cases and never once went to bed.

After those days the District gradually dwindled until it finally ceased to exist, but while it was there the Externs, under the supervision of the Extern Charity, performed a great service, and maternal mortality was extremely low for something like 100 years. I remember before the last war looking up the records of 10,000 consecutive deliveries "on the District", and finding that, including all cases admitted to Guy's, the mortality was less than 1 per 1,000 live births (maternal mortality was in general around 4 per 1,000).

I should perhaps say a little bit more about the room, which was unique, being covered by panels carved by different Externs, and which were often interesting and usually amusing. There was only one small area of wall not so covered, and on this was an oil painting by Stanley Cock, a well-known Guy's figure of years ago. This clever painting showed a butler holding in one arm a white baby and in the other a black one. Underneath was the caption "what will Massah say".

In the Externs room certain rituals were observed, for example, a biscuit could only be taken from the tin with the left hand since this was not used for examinations. Failure to do so meant a fine.

No doubt there are many stories that others could tell about the room.

[EDS. *The correspondence columns are open to contributions as suggested by this note.*]

COMMENSALS OR PARASITES?

Future Student Residence

"This month we have to regret that the further consideration of the proposed New College, to be attached to the hospital, has been postponed for a year. . . ."—*Guy's Hospital Gazette,* September 1877. Even today, ninety years later, this hackneyed expression has been resurrected—and there evolves the question of the inter-relationship between the Hospital, managed by the Governors and the Ministry of Health, and the Medical School financed by the University Grants Commission.

In 1877 the Hospital was controlled by the Treasurer and Governors, but under the supervision of the Charity Commissioners. This proposed new College was a speculation on the part of the School and it was their intention to borrow the money from the Hospital Funds at 4½ per cent interest, but the Charity Commissioners objected, arguing that the School could not provide adequate security that repayment would be made.

In later years the School had acquired the amount required but did not possess a site—the Hospital could not assist. However, in

1890, a College was built on the originally proposed site in Great Maze Pond. The considerable amount of £20,000 was raised by selling Debentures to past Guy's men.

But alas, this building, bombed during the war, saw little of the War Damages Award and has at last been demolished just premature to death from "natural causes".

Again we are presented with lack of financial resources to replace this valuable necessity within the Hospital community. The School has been denied at Government level the cash to replace the College; the University Grants Commission has diverted its quota to the building of new Medical Schools to decentralise London—further accommodation problems?

We are informed of the Hospital's generosity of providing a new site for another hostel. Independent as they may seem, the Hospital thrives from the teaching of undergraduates and postgraduates, and is staffed by the graduates. Its reputation and distinction have stemmed from the high standard of competence of the graduate doctors to maintain "the care of the patients". But can we provide a less efficient training (as indeed we shall without resident students) at a time when a national shortage of doctors demands no allowance for incompetence?

Paradoxically, on the eve of the ascent of the 32-storey Tower Block (a hospital project), wards close through lack of staff and yet we are, perhaps, approaching a time when the student number will be reduced through lack of accommodation. Insignificant the students' role may be, but nevertheless it is an integral contribution for the efficient Hospital routine.

Refused by Government, rebuked by Hospital, do we again hopefully rely on Old Guy's men to raise £$\frac{3}{4}$ million?

J.G.P.

Gladstone, when opening the College in 1890 and commenting on the financial scheme for building the College as being one which was the brainchild of one who might one day be Chancellor of the Exchequer: *"I do not think I ever heard of a more felicitous idea combining boldness and enterprise with the spirit of self denial, and both of these with financial safety, than in the proceedings of your medical and surgical staff when they determined to appropriate their fees in the future to be the basis of this financial operation."*

NURSING SECTION

STAFF CHANGES AND APPOINTMENTS

APPOINTMENTS

S/N L. Kamat S.R.N. (Sir H.N. Hospital, Bombay) to Main Theatres.

DEPARTURES

S/N R. Aynsley-Green, from Addison Ward.
S/N K. Brachel, from Astley Cooper Ward.
S/N J. A. Clayson, from York Clinic.
S/N C. Edwards, from Diplock Ward.
S/N I. Elston, from Addison Ward.
S/N W. Flower, from Cornelius Ward.
S/N J. Hucks, from Ruth Ward.
S/N M. O'Reilly, from Casualty.
S/N J. M. Waters, from Evelyn Ward.

WILLS LIBRARY ANTIQUITIES

4. POSTHUMOUS PUBLICATION

by William Hill

Some weeks ago, when discussing industrial medicine, mention was made of Ellenbogut, whose book was not published for fifty years after it was written. This is not unique and several other instances come to mind, including two whose books were very much post-humously published.

The first is Bartholemew Eustachius who, in 1552, produced a fine series of anatomical plates drawn by himself. For some reason they were never published but remained forgotten in the Vatican library. One hundred and sixty years later they were discovered by Lancisi, physician to Pope Clement XI and published, with notes, in Rome in 1714. The great medical historian, Charles Singer, considered that, had they been published in 1552, Eustachius would have been considered equal with Vesalius as one of the founders of modern anatomy and some anatomists consider that, of the two, Eustachius's plates are the more accurate. They are also the first copper anatomical plates.

Eustachius is recognised as the discoverer of the Eustachian tube, the thoracic duct, the abducens nerve and the adrenal glands. He also is credited with the first accurate description of the uterus as well as giving good accounts of the cochlea, the muscles of the throat and the origin of the optic nerve.

An even longer waiting period is that of William Boghurst, whose book was issued over 220 years after it was written. William Boghurst was a London apothecary who stayed in London during the plague of 1665. In the following year he wrote *Loimographia; an account of the great plague of London in the year* 1665. Why the book was never

published originally is a mystery. One theory is that it was in fact printed but all stocks were burnt in the great fire of 1666 before being issued. It is known that many booksellers lost their stocks in this way. Whatever the explanation, it seems strange that the author, who lived another twenty years, should not have found ways of having it published. The manuscript came into the hands of Sir Hans Sloane and on his death it passed to the British Museum where it remained as Sloane MS 349 until 1894, when it was published by the Epidemiological Society of London with an introduction by J. F. Payne.

Boghurst's account is probably the best contemporary medical account of the plague. During 1665 and 1666 some fifteen books were written and published on the subject, most of which are too trivial to be of great medical interest. Thomson's *Loimotomia* is an exception for it includes the only contemporary account of a post-mortem on a plague victim. Hodge's *Loimologia* has been accepted as a standard account and is another exception. Hodges, however, differs from Boghurst in many respects. It was Hodges who started the theory that the plague started with the infected bales from Holland and this story has been told to generations of children in history lessons. Boghurst, on the other hand, gives a careful account of sporadic cases in 1664 and shows how, in 1665, the plague spread from the west of the city across to the east. This follows the pattern of the Bills of Mortality which are the only statistics available and his account seems the more rational of the two. There is no other support for Hodges and his bales.

Boghurst's theory of the plague was:—

". . . the perfection of putrefaction, or if you like it better in more words, thus: 'The plague or pestilence is a most subtle, peculiar, insinuating, venomous, deleterious Exhalation arising from the maturation of the Faeces of the Earth extracted into the Aire by the heat of the sun, and difflated from place to place by the winds, and most tymes gradually but some tymes immediately aggressing apt bodies'."

Many doctors and apothecaries fled from London but a few stayed, among them Boghurst. He saw as many as forty patients a day, helped lay out bodies, buried them and "commonly suffering their breathing in my face several tymes when they were dying". His reasons for staying were "Every man that undertakes to bee of a profession or takes upon him any office must take all parts of it, the good and the evill, the pleasure and the pain, the profit and the inconvenience altogether, and not pick and chuse; for ministers must preach, Captains must fight, Physitians attend upon the sick. . . ." So he stayed, survived, and wrote his book.

As usual, the books mentioned in this article will be on display in the Wills Library for the next fortnight.

PRESENTATION OF SPECIAL MOBILE DENTAL UNIT

On Tuesday, the 18th July, a specially equipped mobile dental unit costing £5,000 was presented to Guy's Hospital Dental School by the Handicapped Children's Aid Committee. The ceremony took place in the forecourt of the Hospital.

The presentation was made by Mr. J. Myers, Vice-Chairman of the Committee, in the absence of their Chairman, Mr. H. Bourne, who was unfortunately indisposed.

Mr. Myers explained how this small Committee, consisting of some thirty couples, had raised considerable sums of money to donate equipment for research and treatment related to various handicapping conditions. By careful purchasing they had been able to provide many hospitals and special centres with much-needed apparatus. They had done this out of gratitude for the fact that they all had been blessed with healthy, happy children.

Mr. F. S. Warner, Dean of Dental Studies, in his speech of welcome to the guests, said how pleased he was that almost all their members were able to be present. It would give them an opportunity to examine the unit and to talk to the School and Hospital staff who were interested in the project. He was pleased to welcome Mrs. I. Brook and Mr. D. V. House, who represented the Board of Governors.

Mr. Warner introduced Professor W. J. Tulley, who accepted the key on behalf of the Dental School and added his thanks to those of Mr. Warner. He especially thanked Mr. H. Bourne, Mr. H. Rick and Dr. J. Harrington, who had given him so much encouragement with the project.

Professor Tulley pointed out that although this unit might lack the glamour of a piece of life-saving equipment such as a Heart-Lung machine or artificial kidney, it would bring relief to a very large number of handicapped children who suffer considerable pain and discomfort from their mouths, which are often in a very neglected state. These children are often unable to communicate the fact that they are in pain. In other children, dental sepsis places them at considerable risk, particularly if they have congenital heart defects. The Paediatric Department and Research Unit, together with the Cerebral Palsy Assessment Centre, refer a number of patients to the Dental Department for Children. An increasing number of handicappd children are referred by general practitioners, and the Cardiac Department particularly refers children for urgent dental care.

It was explained that this unit will be used in two ways. First to investigate the best methods of providing dental care for seriously handicapped children as out-patients. At present there is no isolated dental surgery which can be used for this purpose and while the unit is in the precincts of Guy's, treatment for these children can be carried out which will greatly reduce the necessity of admitting them to hospital with all its attendant problems. Dental students will be allowed to observe the methods used for treating these children, and this will be a valuable part of their education.

Secondly, with the help of Local Authorities and the Education Authorities who have the responsibility for the dental care of the pre-school and school-age child respectively, a study will be made of the dental needs of these children and a programme of research into preventive dental methods, e.g. topical application of fluoride and instructions to the parents into oral hygiene, will be carried out on a group of very young handicapped children. Attention was drawn to a recent article in "Maternal and Child Care", indicating that with the serious shortage of dental manpower, the whole problem needs further investigation and it is hoped that the work of this unit will

provide information which will act as a stimulus to improve the facilities of this type of treatment throughout the whole country. Although this unit is capable of being used immediately for the first part of this work, further financial assistance will be required to staff it on a full-time basis.

The ceremony closed with a prayer of dedication by Mr. Beevers, the Hospital Chaplain, and the guests were entertained to a buffet lunch.

MUSIC

Antonio Toscanini (1867–1956)

This year is the centenary of the birth of this legendary musician. To most of the modern generation his is just another name, but clearly his impact on both those who saw him conduct and those who played under his baton was fantastic. We can now only appreciate and assess by virtue of his remaining gramophone records—not that he made many and most he did make are in exceptionally poor sound even for their vintage.

R.C.A. have chosen to re-issue, in collected form, many of his recordings at bargain price. His series of Beethoven Symphonies with his own N.B.C. symphony orchestra has always been a classic. His Beethoven readings adhere more closely than any recorded conductor to Beethoven's tempi as indicated by the metronome marks in the scores. This makes all the readings seem on the fast side to modern ears: it also makes for considerable excitement: throughout, the playing is of outstanding quality—dare any player give less than his best with that fiery man liable to explode at him if he failed! Unfortunately, R.C.A. have tagged on some less successful "fill-ups". Prometheus Overture, recorded in 1938 in the notorious 8-H radio studio, sounds as though it is being blown through a hair comb. His travesty of an arrangement of the Opus 135 string quartet in reverse order for full string orchestra is the perfect foil for his high powered and brilliantly successful seventh symphony.

Toscanini was an outstandingly authentic Verdi conductor. He played 1st cello in the 1st performance of "Otello" at the Scala in 1887. He had become friendly with Verdi after he had stood in for a conductor on the company's South American tour in 1881, having never conducted before. He took charge at a moment's notice and conducted entirely from memory. He left two really irreplaceable "desert isle" sets. His Verdi Requiem is still closest to the score and despite coughs of the live performance at Carnegie Hall, is most acceptable. "Falstaff", the product of Verdi's late Indian summer, is realised from broadcast performances in 1947, despite the less than ideal cast, the humour of the performance comes through.

For some, his Brahms may be both too warm and speedy—only listen from the set of the complete symphonies to that of the 4th and compare it with any other available recording. One realises that here is playing of absolute convention, with inner tension and a tremendous overall grasp of the score—the hallmarks of outstanding conducting.

Pre-war, Toscanini visited England often to conduct the newly-formed B.B.C. Sypmphony Orchestra (1930). E.M.I. have issued a record of oddments of this excellent combination: this includes a sparkling account of a Rossini overture. The sound is more reliable than the R.C.A. sets of the early 50's. Post-war, he appeared but once to conduct the orchestra that Karajan was principal conductor of—The Philharmonia—in 1951, for the Festival of Britain.

Toscanini never composed or even taught much. A few have subsequently tried to copy his style but have failed by their lack of dedication. Guido Cantelli, the one great pupil, was killed in an air crash. Clearly the great enigma of his personality remains: if only he had recorded in stereo instead of regarding it as an evil gimmick we might have appreciated him even more.

HEDLEY BERRY

CORRESPONDENCE

A Dirty Word

SIR,—The astonishing statements made by you in Passim of August 19th, under the heading "A Dirty Word" are so misleading as to demand correction. Both the Royal College of Obstetricians and Gynaecologists and the B.M.A. have been most active in putting forward the Profession's views on therapeutic abortion to those responsible for the Bill, at present still under discussion.

In April, 1966, the Royal College issued its report unanimously endorsed by Council. This report was published in full in the B.M.J. and given wide Press publicity. The B.M.A. set up an Abortion Sub-committee which also issued a report in July, 1966 before the second reading of the Steel Bill. In order to present a united front, representatives of the B.M.A. and the Royal College together had meetings with the Home Secretary, the Minister of Health and Mr. David Steel and also published a joint statement before the Committee stage of the Bill. All through the Committee stage, the Royal College and the B.M.A. were together consulted by Mr. David Steel and other members of the Committee. Many members of Parliament were briefed on the Profession's views.

So that there should not be any misunderstanding before the third reading of the Bill, representatives of the Royal College and the B.M.A. saw the Ministers and Mr. David Steel again. They also wrote a letter to *The Times*, a copy of which was sent to every Member of Parliament.

It would take too long to list the numerous statements to the Press and Press Conferences held at the B.M.A. and the Royal College.

One consequence of its active participation in the framing of the Bill, is that the Profession must be held to some extent responsible for it. To say that we have been silent is just not true.

Yours etc.,

T. L. T. LEWIS.

109, Harley Street,
London, W.1.

Herpes and Chickenpox

SIR,—It was most gratifying to find that my quizette on infectious diseases had evoked a response in your correspondence section. I shall be grateful for an opportunity to answer Dr. R. E. Smith's letter for, in my opinion, it contains statements which are not only misleading but factually incorrect. Firstly, concerning the incidence of a generalised, if sparse, varicella eruption together with herpes zoster, C. F. L. Hill[1] quotes an incidence of 31 per cent in patients seen from 1947 to 1953, and states that it is his impression that varicella lesions are seen in about half of all elderly cases of herpes zoster. Buckler and Jones[2] quote an incidence of 51 per cent in 63 successive cases of zoster seen between 1960 and 1965. This range of 30-50 per cent is in keeping with my own experience and is not a reflection of a special epidemic.

As an example of a special epidemic, Dr. Smith quotes an incidence of submaxillary gland involvement in mumps of 25 per cent. In my own experience and in that of the senior physician at the Infectious Diseases Unit attached to Guy's[3], at least 50 per cent of cases of mumps have sub-maxillary gland involvement at some stage of their disease if they are observed carefully enough.

Finally there is the question of whether or not herpes zoster can be contracted from a case of chickenpox or from another case of herpes zoster. Both chickenpox and zoster are common conditions, and it would seem most likely that zoster would occasionally follow chickenpox by chance. There is no epidemiological proof that zoster can be "caught" from chickenpox, but I think most physicians

have seen cases in which this seems to have been the case. The situation is much the same today as outlined by I. M. Librach in 1965[4], but a great deal of work is now being done on zoster-varicella antibodies titres both in herpes zoster and varicella, and these studies may give an answer to this problem in the future.

Yours, etc.,

I. G. McGILL

Guy's Hospital,
London, S.E.1.

References

(1) Hill, C. F. L., Brit. Med. J. 1965, 1. 1248.
(2) Buckler, J. M. H., and Jones, N. B. S., Brit. Med. J. 1965, 1, 1309.
(3) Brown, E. H., Personal Communication.
(4) Librach, I. M., Brit. Med. J. 1965, 1, 1309.

Cannabis

SIR,—Not being a reader of the *Daily Express* I have no idea what they printed, but the inference from the letters in the August 19th *Gazette* correspondence column under the general heading "Potty" suggests some significant misapprehensions. I have never advocated the indiscriminate use of cannabis indica (or of any other intoxicant) for personal pleasure or experience; nor indeed did *The Times* petition. What the petition suggested was that such use be treated legally as a misdemeanour, pending appropriate medical research into its effects.

Of course, we have prescribed it on occasion at Guy's (Guy's Hospital Reports Vol. 103, **4**, p. 330); just as our colleagues have prescribed, and rightly continue to prescribe, morphia and heroin. But while the latter remain available to the medical profession, cannabis has become an exclusively black market commodity, liable to contamination with morphia or heroin to make it addictive, and thereby render its peddling commercially worthwhile.

That is the crux of the present confusion, and it is perhaps an ironic endorsement of this avoidable ignorance that not one of your correspondents seems to have grasped this point.

Yours, etc.,

D. STAFFORD-CLARK

York Clinic,
Guy's Hospital.

SIR,—Judging by the quality of the letters opposing his views, Passim's article on hashish smoking (5th August) certainly seems to have stirred up the mud at the bottom of the pond.

In my view the contributions of Messrs. Stoker, Burns, and Murphy reflect a total lack of rational thought.

Mr. Stoker feels that many in the Medical Profession wish that cigarette smoking were illegal, but this is of course quite irrelevant to the question as to whether the State has the *right* to ban such an activity. And those now enjoying a quiet smoke might ponder on Mr. Stoker's desire that the police should be empowered to drag them from their homes and clasp them in prison for this heinous offence.

Mr. Burns' letter makes two points. Firstly he takes issue with Passim's contention that "pot" smoking harms nobody but the smoker (assuming that is, that it harms any one at all).

Of course, what Passim meant was that it does not cause the type of harm to others that the law can possibly take cognisance of. Now I do not know if Mr. Burns means that the sort of harm of which he writes, i.e. callous or irresponsible behaviour towards his family and employer, etc., by the hashish user, is sufficient to justify making "pot" smoking a criminal offence, but if he does he will find himself in some difficulty in explaining why a whole host of other human activities, from alcohol consumption, though gambling and fornication, to attempted suicide should not also be made contrary to the criminal law on the same grounds. If he does not mean this then his point is entirely irrelevant.

Mr. Burns' second point is that in writing as it did Passim was encouraging people to smoke "pot". Well, I do not know what meaning Mr. Burns would ascribe to the word "encouragement", but Passim's contention that the law should adopt a neutral position on this issue surely cannot be described as encouragement in any valid sense of that word. It was not exhorting people to smoke hashish, but merely advocating that they should be free to decide the question for themselves.

With reference to Mr. Murphy's letter, one can only assume that he was joking.

In conclusion I would like to say that I do not personally approve of "pot" smoking, but feel obliged nevertheless to defend the fundamental right of any *adult* human being to be free to do as he pleases provided his conduct does not cause harm to innocent individuals other than himself, or clear and significant harm to the community as a whole.

Those who seek to restrict the freedom of the individual bear the burden of proving that the activity they desire to curtail causes such harm, and I have yet to read anything in this journal, or outside it, which personally satisfies me that, with regard to "pot" smoking, those who would preserve the law in its present state have discharged that burden.

Yours, etc.,

J. M. H. GRAHAM

"Inglenook",
Bashurst Hill,
Itchingfield,
Nr. Horsham, Sussex.

Dare Quam Accipere

SIR,—We should like to draw your attention to yet another petty theft in the Medical School. On this occasion the UNICEF collecting box on the counter in the Wills Library has been removed. I feel sure that those concerned will be surprised at the generosity of other people in the School. We happen to know how much was in the box at the time and would like to thank, on behalf of UNICEF, all those who give regularly and anonymously to this fund, and hope that they will not lose all faith in human nature, and continue to support this effort. A new box will shortly replace the missing one.

Yours, etc.,

(Miss) C. A. M. STUBBINGS,
Deputy Librarian

Wills Library,
Guy's Hospital.

NOTICES

Guy's Hospital Nurses' League

A Reminder

The Cocktail Party will be held on Saturday, 21st October, 1967, 6.00 to 8.00 p.m.

Will Members please apply for tickets to the Honorary Secretary, Matron's Office, Guy's Hospital, before 2nd October.

Fizzio Ball

This Ball will be held on 15th September, 1967, at the Hurlingham Country Club. Dancing to Bill Savill and his Band, and The Tropicanos. Black tie. Double tickets, 4½ guineas, obtainable from any physio.

SPORT

CRICKET TOUR

Friday, August 4th to Friday, August 11th.
Played 6, Won 1, Drawn 2, Lost 3.

The annual Cricket Tour to Sussex this year saw the introduction of the Ali-shuffle-and-song routine into after-match revelries; the taking of hors-d'oeuvres before curries; A. A. Gordon-Thomson demonstrating his almost perfect technique, even on unhelpful wickets; the reintroduction of a well-supported Selsey Run; a most impressive evening performance by the Secretary at Bognor; the junior member of the side wrapping himself round Bognor's trees ecstatically; the captain and senior pro. making heavy weather of the return journey from Cuckfield, to the extent of covering all of the 30 miles in approximately 3½ hours; Chase and Rowlands proving their versatility as performers both on and off the field; the delightful sound of the previously infallible Neville succumbing on Wight seven; and most important of all, fine, sunny weather all week.

Alas, from the cricket point of view, the week was rather disastrous. Only one game was won, three were lost and two drawn. There seemed to be a loss of form by nearly all the team for most of the tour. This was especially true of our batsmen who, as a whole, completely lost their confidence. The bowling did not come up to expectations either, consistently lacking penetration. Mention must be made of Neville's wicket-keeping; it was neat and tidy in all his four games, in which he claimed eight stumpings.

The tour opened with a disastrous collapse at Basingstoke. The batting disintegrated in the face of attacking seam bowling by Ives and Bovill.

The former wrecked the innings with a spell of four wickets in five balls, including the hat-trick. His victims were Butchey, caught behind, and Clark and Silk, both bowled playing back. Appleby lasted two balls, and Swift a few more before hitting across a straight one. From a scoreboard reading 16 for 7, Davies led a partial recovery; he played well to make 24 and enable Guy's to limp to a total of 57.

Guy's managed to save some prestige by tight bowling and fielding Crafts raised our hopes by claiming two wickets with consecutive balls but well as he, Beacham and Clark bowled, Basingstoke made the required runs in an hour and a half for the loss of four wickets.

Logically, we arrived at the "Red Lion" at Selbourne rather earlier than usual; the drive to Thatchings was negotiated safely by all, though somewhat erratically by some!

On the Saturday, we played Hayling Island for the first time.

They struggled to reach a total of 128: and and this despite the use of occasional bowlers who all bowled down to form, especially our senior pro, who nevertheless included only one wide in his over! The principal wicket-takers were Crafts and Butchey, whose skilful flight bemused the batsmen. In addition, Thompson and Chase had two remarkably good catches.

When Guy's batted, it quickly became apparent that Hayling's bowling was in a different class to their batting, and runs were hard to come by. The score had slumped to 40 for 4 before Rowlands and Appleby began to retrieve the situation. Rowland's valuable innings ended when he was l.b.w. for 26.

Appleby continued to enjoy more than his fair share of luck before being bowled. The last over started with Guy's needing five runs to win and with three wickets left. Davies was stumped off the first ball, but fortunately the captain's blushes were spared when Crafts hit the fifth ball for the winning boundary.

That evening, an ex-Guy's man, Dr. Broughton, working in practice on the Island, very kindly invited us along to his club. "The Technique" was first demonstrated here, and in addition Rowlands, though scoring heavily in other directions, lost many points in some eyes!

Sunday saw the traditional game against Bognor.

The start was delayed for half an hour because of overnight rain, when Bognor were inserted in the erroneous view that the pitch would improve. The Guy's bowling and fielding before lunch was as good as at any time this season, but unfortunately two chances were missed that were to prove to be expensive. Lunch was taken with the score at 63 for 2; after the interval, as the wicket dried out, the Bognor batting gradually got on top. J. Davies' attractive innings of 65 was only ended by a well-judged catch by Rowlands; Williams made a sound 41; and finally Thomson, guesting for Bognor who were one short, stroked an impressive 27 not out, displaying strokes never before unveiled for Guy's. Crafts and Pearson both bowled well, the latter without any luck at all.

Bognor's declaration left Guy's two and a half hours to make the 204 needed to win. After a slow start, wickets began to fall in the chase for the runs. Butchey was unluckily out for a useful 32, during the course of which our square-leg umpire was temporarily silenced by a horrible blow on the back of the head from a full-blooded hook. On this occasion, silence was indeed golden! It was left to Swift and Rowlands to raise hopes that Guy's might reach

their target. Rowlands was bowled after a good attacking innings, while Swift's knock ended just as he had reached his half-century. Guy's were eventually bowled out for 143 with 15 minutes to spare.

As always, a highly sociable and entertaining evening followed. The "Ali-shuffle", various techniques, hors d'oeuvres, apparent shortening, constables, and fried rice were all seen, while the senior pro's cap and the captain's shoe were not!

Ferring were the opponents on Monday. Bert Lock, the M.C.C.'s Inspector of Pitches, would probably have had difficulty in finding the wicket, let alone commenting on it! This was explained by the simultaneous failure of three mowers.

In spite of the appearance, Butchey bravely batted on winning the toss, and even more bravely emerged from the railway carriage to open the innings with Gillham. In fact, the wicket was not as bad as predicted, and the opening partnership was worth 83 at a run-a-minute when Gillham was out for a sound 31. In came Clark, fortified by a lunch-time session which had obviously not yet reached the sedative stage, to play a brilliantly aggressive innings. He reached 50 in half an hour, and put on 118 with Butchey in 40 minutes; the Ferring bowlers were smitten to all corners of the ground. Guy's declared at tea at 211 for 2, with "Sunshine Butchey" 71 not out, leaving Ferring five more minutes batting time than they had had.

In a pathetic response, Ferring never at any time made any real attempt to score the runs. Admittedly, Guy's possessed the better attack, and Davies was fairly hostile, but one felt that any effort would have been better than none. Pearson, opening the bowling, bowled well to claim the first three wickets. Davies, bowling to an unprecedented five slips, then got two wickets, both being good catches by Pearson in the gully. However, the sixth wicket pair, consisting of father and son, batted with considerably more ability than their predecessors, and forced a draw with an unbroken stand of 87. Not even Thomson could break their partnership!

Tuesday and Wednesday were free. Seven of the party played as guests for Bognor, and all seemed to perform with rather more success than for Guy's! Goodwood golf course also received its annual thrashing by the boys. The Selsey Run took place on Wednesday evening, and claimed its fair share of victims; altogether, seven "towers" embarrassed their gastric mucosae on this occasion!

Thursday was one of the blackest days for Guy's cricket for a long time. Cuckfield. in a whole-day game, won by an innings and 20 runs.

In the morning, good seam bowling by Thacker and late scoring by Elliott, reduced Guy's to 54 for 9 by lunch. Thomson, first with Neville and then with Beacham, was the only batsman to provide much resistance and made 28 before being well caught in the slips. Though the Cuckfield openers bowled well, they were helped by very poor batting; Silk and Rowlands were the only ones to receive the infamous "unplayable ball".

Pearson did not seem keen to bother the scorers after lunch, leaving Cuckfield to score 55 to win. This they did, and then continued their innings until they declared at tea at 176 for 4. A by now thoroughly demoralised and confidence-lacking Guy's team batted without any conviction or purpose after tea, and were bowled out a second time for 102; this time by the spinners, leaving Cuckfield winners by an innings.

In previous years, the Tour had ended on the Thursday, but this year it was extended by a day to enable us to play Chichester Priory on the Friday. This new fixture was in their cricket week on their lovely ground in the heart of Chichester.

Taking into account the reputation of their seam attack, who had already dismissed two sides for under 60 earlier in the week, and the form of the Guy's batting, Chichester were asked to bat first. Their openers, although beaten several times by Beacham and Crafts, batted chancelessly until lunch when the score was 101 for no wicket. One felt that there had been an air of inevitability about the morning's play.

However, things changed dramatically after lunch, helped by the appearance of two recent acquaintances on the boundary, giving a much-needed stimular to the fielding. The first wicket fell at 115, when Crafts bowled their better opener. His partner soon followed, well caught by Chase at mid-off. From then on, against good fast bowling by Crafts, and unusually accurate leg-spin by Appleby, wickets tumbled in the quest for quick runs. In the next hour the remaining eight wickets fell for 43 runs. Appleby, helped by bad hitting across the line, good catches by Clark and Davies, and two stumpings by Neville, finished with six wickets. Crafts was most unlucky, and had scant reward for a really good piece of bowling.

When Gillham and Thomson opened for Guy's it soon became obvious that a win was going to be hard-earned against their battery of seamers. At tea, both openers were out; after the interval, Clark and Chase batted well against good bowling until Clark was bowled having a heave to mid-wicket. Chase and Appleby were both beaten by movement off the pitch playing back, and it quickly became a matter of survival, with victory out of the question.

As Pearson went out to join Beacham with 20 minutes left, with all due respect to our Numbers 10 and 11, long odds would have been quoted against Guy's drawing. However, both batted very sensibly and well, and achieved the "impossible". Thus, at any rate, the tour ended on a note of defiance from our batsmen, and a draw was salvaged against good opposition.

SCORES

v. Basingstoke
Guy's, 57. (Davies, 24.)
Basingstoke, 61 for 4. (Crafts, 3 for 33.)

v. Hayling Island
Hayling Island, 128. (Butchey, 4 for 28; Crafts, 3 for 36; Appleby, 2 for 19.)
Guy's, 131 for 8. (Appleby, 57; Rowlands, 26.)

v. Bognor
Bognor, 203 for 7 dec. (Crafts, 3 for 21.)
Guy's, 143. (Swift, 50; Butchey, 32; Rowlands, 22.)

v. Ferring
Guy's, 211 for 2 dec. (Butchey, 71 not out; Clark, 67; Gillham, 31.)
Ferring, 153 for 5. (Pearson, 3 for 48; Davies, 2 for 34.)

v. Cuckfield
Guy's, 54 (Thomson, 28) and 102. (Rowlands, 29 not out; Clark, 21.)
Cuckfield, 176 for 4 dec. (Pearson, 2 for 62.)

v. Chichester Priory
Chichester, 162. (Appleby, 6 for 40; Crafts, 2 for 45.)
Guy's, 95 for 9. (Clark, 27.)

Team

M. Appleby, J. Butchey, R. Clark, R. Beacham, D. Silk, P. Swift, C. Pearson, A. Gillham, A. Thomson, C. Neville, W. Davies, B. Rowlands, D. Crafts, R. Chase.

M. I. APPLEBY

CRICKET CLUB—SEASON 1967

Averages.

Batting

Qualification: 8 innings.

	Innings	Not out	Runs	H.S.	Avg.
P. Swift	14	3	369	93	33.5
M. Appleby	30	5	665	112*	26.6
J. Buchey	24	2	548	71*	24.8
R. Clark	29	—	617	80	21.3
D. Crafts	19	7	236	30*	19.7
B. Rowlands	8	2	118	31*	19.7
R. Chase	22	1	381	53	18.1
D. Silk	23	1	363	57	16.5
W. Davies	11	2	140	58	15.5
A. Gillham	17	2	206	57*	13.7
D. Thomas	9	1	96	47	12.0
A. Thomson	21	—	223	28	10.6
R. Beacham	14	12	19	8*	9.5
C. Pearson	19	5	76	14	5.4
C. Neville	8	1	20	8	2.9

* *not out.*

Bowling

Qualification: 10 wickets.

	Overs	Maidens	Runs	Wickets	Avg.
S. Davoodbhoy	125	13	390	32	12.2
D. Crafts	342	85	876	52	16.9
C. Pearson	271.2	55	815	42	19.4
M. Appleby	119.3	15	444	20	22.2
R. Clark	208.2	44	635	27	23.5
R. Beacham	273	57	863	27	31.9

HOSPITAL INFORMATION

APPOINTMENTS VACANT

GUY'S HOSPITAL, S.E.1.

Applications are invited for the post of **Registrar in Child Psychiatry,** with duties to commence on 1st October, 1967, and appointment for one year in the first instance. Forms of application are obtainable from the Superintendent, Guy's Hospital, and should be returned not later than **8th September, 1967.**

GUY'S HOSPITAL, S.E.1.

Applications are invited for the post of **Junior Medical Registrar at St. Olave's Hospital,** with duties commencing 1st October, 1967, and appointment for one year. Forms of application are obtainable from the Superintendent and should be returned not later than **11th September, 1967.**

APPOINTMENTS

GUY'S HOSPITAL

Allocation of Medical and Surgical Registrars, 1967/68

To take effect from October 1st, 1967

Medical Registrars

Dr. Mann and Dr. Scott	Dr. P. W. R. Harris
Dr. Hardwick and Prof. Trounce	Dr. C. N. Mallinson
Dr. Baker and Dr. Houston	Dr. R. D. Hill
Dr. Kauntze and Dr. Joiner	Dr. C. I. Roberts
Prof. Butterfield and Dr. MacLean	Dr. I. G. McGill

Junior Medical Registrars

Dr. Mann and Dr. Scott	Dr. I. A. Baker
Dr. Hardwick and Prof. Trounce	Dr. A. J. Richards
Dr. Baker and Dr. Houston	Miss A. Y. Coxon
Dr. Kauntze and Dr. Joiner	Dr. G. A. Pettitt
Prof. Butterfield and Dr. MacLean	Dr. J. Rogers

Surgical Registrars

Prof. Sir H. Atkins and Mr. Glover	Mr. R. J. Heald
Mr. Wass and Mr. Brain	Mr. J. C. Bull
Mr. Blackburn and Mr. Beard	Mr. S. A. R. Cooke
Mr. Lawrie and Mr. Maynard	Mr. W. G. Hartfall

Junior Surgical Registrars

	October to March
Mr. Maynard/G.U.	Mr. Keates
Mr. Brain/G.U.	Mr. Nicolaides
Mr. Beard and Mr. Crabbe	Mr. Dowlatdad
Neurosurgery	Mr. Metzner
	April to September
Mr. Maynard/G.U.	Mr. Dowlatdad
Mr. Brain/G.U.	Mr. Metzner
Mr. Beard and Mr. Crabbe	Mr. Nicolaides
Neurosurgery	Mr. Keates

MEDICAL REGISTRARS AND JUNIOR REGISTRARS WITH DUTIES IN SPECIAL DEPARTMENTS

Cardiac Clinics	
Dr. Baker	Dr. R. D. Hill
Dr. Kauntze	Dr. C. I. Roberts
Chest Clinic	Dr. P. W. R. Harris
Asthma Clinic	Dr. R. D. Hill
Diabetic Clinic	Dr. C. N. Mallinson
V.D. Clinic	
Endocrine Clinic	Dr. M. N. Maisey

P. J. HELLIWELL,
Superintendent

August, 1967

GUY'S HOSPITAL
JUNIOR STAFF APPOINTMENTS
1967/68

The following appointments and re-appointments have been made for the period beginning October 1st, 1967:—

WHOLE-TIME APPOINTMENTS
MEDICAL

Medical Registrars
Dr. J. R. R. Spurrell (Lewisham Hospital)
Dr. R. D. Hill
Dr. C. N. Mallinson
Dr. P. W. R. Harris
Dr. I. G. McGill
Dr. C. I. Roberts
Dr. S. McHardy-Young (On unpaid leave)
Dr. P. J. Winter (New Cross Hospital)
Dr. N. E. Jensen (St. Olave's Hospital)
Dr. C. S. Ogg (Dialysis Unit)
(Dialysis Uinit)

Junior Medical Registrars
Miss A. Y. Coxon
Mr. G. A. Pettitt (from 31.10.67)
Mr. I. A. Baker
Mr. A. J. Richards
(St. Olave's Hospital)

Surgical Registrars
Mr. S. A. R. Cooke
Mr. J. C. Bull
(St. Olave's Hospital)
Mr. W. G. Hartfall
Mr. R. J. Heald
Mr. A. B. Richards (St. Olave's Hospital)

Junior Surgical Registrars
Mr. A. Dowlatdad
Mr. J. R. W. Keates
Mr. P. J. Metzner
Mr. A. N. Nicolaides

Registrars in Throat and Ear Department
Mrs. C. M. Wengraf (Lewisham Hospital)
Mr. J. G. F. Fraser
Mr. J. A. S. Carruth
Mr. J. M. Fox

Obstetric Registrars
Mr. E. P. W. Tatford
Mr. J. D. Ellis
Mr. M. F. Terry (Farnborough Hospital)

Cytologist
Mrs. J. Vale

Registrars in Physical Medicine
Miss J. Colston
Dr. I. Vadasz (Bromley, Orpington and Sevenoaks Group)
Dr. M. L. Ingpen
Dr. B. D. O. Smith

Registrar in Cardiology
Dr. D. C. Fluck

Junior Registrar in Cardiology
Dr. R. Gilkes

Registrars in Clinical Pathology
Dr. O. H. B. Gyde
Miss S. Amin
Miss J. M. Parker
Dr. B. A. N. Read
Dr. A. Sayeed
Dr. R. A. Leng

Registrar in Haematology
Dr. J. L. Raven

Registrar in Endocrinology & Radioisotopes
Dr. M. N. Maisey

Registrars in Psychological Medicine
Dr. D. I. Brough (Bexley Hospital)
Dr. A. C. Smith
Dr. M. C. Bott
Dr. P. V. Nair
Miss B. A. Davies (Bexley Hospital)
Miss I. Abey-Wickrama
Dr. J. A. Carson
Dr. K. F. Standage
Dr. F. M. Yasin (St. Olave's Hospital)
Dr. J. Colville (St. Olave's Hospital)

Registrars in Child Psychiatry
Dr. K. A. O'Keeffe
Dr. P. A. Murray

Orthopaedic Registrars
Mr. M. A. Nelson (On unpaid leave)
Mr. S. J. Lam
Mr. A. L. Gunn
Mr. P. C. Shaw

Orthopaedic and Casualty Registrar
Mr. W. Bunting

Genito-Urinary Registrar
Mr. J. F. Flannery

Dermatological Registrars
Dr. A. Bowyer
Dr. J. L. Verbov

Registrars in Diagnostic Radiology
Dr. J. R. Barnett
Dr. A. B. Dew
Dr. N. J. Strickland
Miss B. C. King
Dr. J. S. M. Beales
Dr. M. C. Pearson

Registrars in Radiotherapy
Dr. J. Boyd
Dr. M. E. Haque

Registrars in Neurology
Dr. R. G. Lascelles

Registrars in Ophthalmology
Mr. H. P. B. Whitty
Mr. E. W. G. Davies

Junior Registrar in Ophthalmology
Mr. P. D. Davies

Paediatric Registrars
Dr. S. R. Meadow (Unpaid leave)
Dr. L. Rosenbloom
Dr. M. J. Dillon (Brighton Group)

Registrars in Thoracic Surgery
Mr. A. K. Yates
Mr. B. A. Ross
Mr. J. A. Dyde

Registrars in Anaesthetics
Dr. M. Lindsay
Dr. G. D. Thomas
Miss P. B. Hewitt
Dr. G. R. Gerson
Dr. J. C. Simpson
Dr. M. C. W. Morgan
Dr. D. J. Openshaw
Dr. W. J. O'Brien
Dr. T. J. B. Harris (Brighton Group)

Registrars in Geriatrics
Dr. H. M. Gillespie (Hastings Group)

Registrars in Venereology
Dr. J. J. Rohatiner
Dr. D. M. Wright

DENTAL

Registrars in Children's Department
Mr. J. Metcalf
Mr. S. I. M. Robinson

Orthodontic Assistant
Mr. C. D. Stephens

Registrars in Clinical Dental Surgery
Mr. D. H. Gibb
Mr. W. T. Lamb

Registrars in Minor Oral Surgery
Mrs. A. Robinson
Miss S. L. O'Leary

Registrars in Preventive Dentistry
Mr. C. H. Forsyth
Mr. A. B. Hewitt
Mr. D. G. Stone
Mr. D. W. Macfarlane

Registrars in Dental Casualty
Mrs. A. Robinson
Mrs. G. C. D. Ross

Registrars in Dental Prosthetics
Mr. A. G. Buchanan
Mr. D. M. Griggs
Mr. P. B. Morris
Mr. A. J. Stewart
Miss V. Beaton
Mr. M. Malleson
Mrs. A. Robinson

Registrars in Conservative Dental Surgery
Mr. R. C. Paterson
Mrs. S. Roberts
Mr. M. R. Setchell
Mr. G. G. Ashby
Mr. R. A. W. Wakeley
Mr. R. A. Ellis
Mr. B. D. Glynn
Mr. D. F. Howard
Mrs. M. K. Stephens
Mr. A. Winskill

Registrars in Dental Radiology
Miss V. J. Beaton
Mr. P. D. Davies

Dental Officer to treat In-Patients and to Salomons Centre
Mr. F. M. Titley

P. J. HELLIWELL,
Superintendent.

August, 1967.

PASS LISTS

ROYAL COLLEGE OF OBSTETRICIANS AND GYNAECOLOGISTS

M.R.C.O.G.

D. G. Daniel

UNIVERSITY OF LONDON

M.S.

O. H. Shaheen

Third (B.D.S.) examination in dental surgery

I. J. Pitman
(Distinguished in prosthetic surgery)

Elaine D. Black
R. A. Burroughes
Elizabeth A. Cocks
J. K. Crafts
R. A. Cramp
R. Davies
M. H. Dods
I. Dunn
S. W. Finch
Jacqueline E. K. Hawley
Penelope J. Heather
H. R. Hirsh
M. G. Hodge
J. M. Hudson
R. W. Jones
C. H. W. Lee
J. A. Mander
J. H. J. Milliner
M. W. S. Newlands
Frances M. Pratt
C. H. Rowlinson
P. B. Swiss
M. S. F. Taylor
A. S. Usiskin
Diana J. Wagstaff
C. W. Winning

Academic Diploma in General Biochemistry

*P. M. Carter
*Yvonne F. S. Glen
*J. O. Soul
M. Sutton
*C. W. G. Turton

*Awarded a mark of distinction

UNIVERSITY OF LONDON

Third B.D.S. Examination in dental surgery

Part 1

R. J. Beacham
M. G. H. Bishop
Joan R. L. Boulton
N. G. Daws
K. A. Eaton
A. R. Froom
J. C. Gaskell
D. H. Haines
M. L. Ham
N. J. B. Head
M. C. Mace
P. R. M. Oaten
A. A. D. Reed
M. F. Richard
J. S. Robson
D. J. Sherwood
A. J. Stevens
D. M. Stevens
Anne C. R. Tanner
A. P. Taylor
N. J. Taylor
N. A. P. Thompson
M. R. Townsend
Elizabeth H. Wilson
R. M. Wilson

Part 2

M. P. D. Adams
R. J. Beacham
P. J. Burton
Joan R. L. Boulton
K. A. Eaton
A. R. Froom
C. MacL. Gebbie
M. L. Ham
N. J. B. Head
Anne B. Lysholm
M. C. Mace
Pauline F. Murphy
P. R. M. Oaten
F. R. Porter
A. A. D. Reed
J. G. Ritchie
D. J. Sherwood
R. A. Stares
Alison J. Stevens
D. M. Stevens
Anne C. R. Tanner
M. R. Townsend
R. D. Webb
R. M Wilson

Part 3

R. L. Anderson
Marion J. Apthorp
Jeanne E. Baker
K. R. Band
G. R. Barker
Philippa M. Bevis
D. M. Blakesley
Carol A. Blanks
A. S. Blinkhorn
P. A. Breen
P. G. Budden
P. V. Carrotte
Anne P. Collins
Isla M. Copeland
J. G. Cragg
J. S. Cunliffe
D. W. Davidson
A. J. Davis
W. H. Douglas
Carina Dovy
G. N. Farber
A. G. George
P. N. Gooder
P. A. Haigh
T. G. Haywood
Sally E. Hunter
R. W. Kendrick
J. D. King
D Lindridge
I. J. Mackenzie
K. W. Malia
S. A. Marsh
M. J. Nockles
J. A. Osborne
C. R. Pearson
A. G. Pullinger
W. M. Rosten
R. H. Salt
Anita L. Sharp
B. J. Smith
Elizabeth J. E. Smith
M. P. Stearns
K. Taylor
G. M. Thomas
Elizabeth A. C. Tippett
P. B. Veale
P. R. Walker
Elizabeth J. Watson
A. Watts
Deborah M. Wiggins

PUBLICATIONS BY GUY'S MEN

Adams, C. W. M. *Vascular histochemistry.* London, Lloyd-Luke, 1967.

Calne, R. Y. *Renal transplantation.* 2nd edition. London, Arnold, 1967.

Clarkson, P. W. and another. Modern mammaplasty. *Brit. J. plast. Surg.*, 1967, **20**, 297.

Cohen, S. M. Arteriovenous fistula *in Clinical Surgery.* Ed. C. Rob and R. Smith, vol. 14, London, Butterworth, 1967.

Emslie, R. D. Prevention in peridontal disease. *Internat. dent. J.*, 1967, **17**, 320.

Ernsting, J. *Some effects of raised intrapulmonary pressure in man*, London, Mackay, 1967.

Hallpike, C. S. Observations on the structural basis of two rare varieties of hereditary deafness. In Ciba Foundation Symposium on *Myotatic, kinesthetic and vestibular machanisms.* London, Churchill, 1967, p. 285.

Hawkins, C. F. *Speaking and writing in medicine.* Springfield, Thomas, 1967.

Kinsbourne, M. Left or right-handed? *Health*, 1967, **4**, 109.

Robin, R. G. and others. *Synopsis of otolaryngology.* 2nd edition. Bristol, Wright, 1967.

Thurston, G. *The Clerkenwell Riot.* London, Allen & Unwin, 1967.

Turk, J. L. *Delayed hypersensitivity.* Amsterdam, North-Holland, 1967.

Tulley, W. J. Prevention in orthodontics within the scope of the school programme. *Internat. dent. J.*, 1967, **17**, 368.

PERSONAL

FREEHOLD, semi-det. three bedroom house for sale £6,350. Adjacent to Station Square, Petts Wood. Details: Orpington 24930.

CHANGES OF ADDRESS

Michael Awty, Iscombe House, Lingfield Road, East Grinstead, Sussex. East Grinstead 25266.

Dr. J. M. Dawson, B.A., M.B., B.Chir., M.R.C.P., D.M.R.D., Micklegate, Pine View Close, Haslemere, Surrey. Haslemere 2418.

N. J. Knott, Woodbury Lodge, Exton, nr. Exeter, Devon.

Mrs. P. Ledger (née Shart), S.R.N., O.N.D., 1, Conholt Road, Andover, Hants. Andover 2766.

Dr. B. C. Mallaband, 37, Woodlands Road, Bushey, Herts. Watford 21547.

Jean and Ian McColl, c/o Department of Surgery, Harvard Medical School, 330, Brookline Avenue, Boston, Mass. 02215. (From August until December, 1967.)

Dr. and Mrs. D. L. Morgan, Kirri Billi, 86, Stakes Road, Purbrook, Hants. Waterlooville 51248.

D. E. Pitts, 91, Romilly, Beach Road, Strand, Cape Province, S.A.

Dr. and Mrs. G. M. Preston, No. 7, Sarah Swift House, Kipling Street, S.E.1. Hop. 1824.

Dr. and Mrs. M. D. Steyn, 16, St. Helens Road, Hayling Island, Hants. Hayling Island 4486.

Mr. A. Winskill, B.D.S., L.D.S., R.C.S.(Eng.), The flat, 12, Sydney Road, Haywards Heath, Sussex. Haywards Heath 4114.

MARRIAGES

EASTBURN—ECKETT—On Saturday, 29th July, at Christ Church, Purley, Miss Anthea Eckett, S.R.N. (Guy's 1960-64) to Lieutenant Alan F. Eastburn. Present address: Officers' Mess, 2 Div. H.Q. Signal Regt., B.F.P.O. 22

PRESTON—WILKINS. On 14th August, 1967, at Southwark Town Hall, George Mason Preston to Muriel Ann Wilkins (née Girdlestone).

DEATH

HASTINGS—On June 30th, 1967, Roy Marcus Hastings, L.D.S., R.C.S.

We would like to remind our readers that all copy for inclusion in the Gazette must be received eight days before the publication date.

Personal notices one shilling per word (Minimum £1. 1s. 0d.)
Birth, Marriage, Death and Change of Address notices are without charge to subscribers.
Non-subscribers will pay £1. 1s. 0d. for all notices other than Personal.

GUY'S HOSPITAL GAZETTE

EDITORS D. S. ROBINS and C. B. BROWN
SPORTS CORRESPONDENT J. G. PAYNE
NURSING CORRESPONDENT E. A. MALPAS

FORTNIGHTLY TWO SHILLINGS VOLUME 81 NUMBER 2065

The opinions expressed in these columns are solely those of their authors and are not to be taken as the views of the Hospital as a whole.

PASSIM

Medico-Legal Series

It would be true to say that in an average working day every medical practitioner comes into contact with the law of the land in one form or another. He is carefully taught how and what to say, what to write and what not to write, who to speak to and to whom he should offer bland pleasantries. From forms and documents in their anonymous tedious profusion to the very personal activity in the law courts, the doctor plays a never-ending game of professional bridge with the lawyer, and with variable *panache*. A few even play holding the "we" cards in one hand and the "they" in another as coroners. And as in other forms of the game there is inestimable advantage in knowing, if not the exact nature of the opponent's cards, then the manner in which they are likely to be played.

In this issue we begin a series of six commissioned articles written by Professor Keith Simpson, of the Department of Forensic Medicine at Guy's and a well-known and respected authority in both the hospital and courts. Under the general heading "Current Medico-Legal Problems", he succinctly delineates a number of legal and social problems with which the doctor is particularly liable to become involved during his professional career.

Universal Health

With the national coffers rapidly containing more air than ducats Socialist social policy has come under the scrutiny of the party bosses with the same rigorous dissection one more commonly associates with the Prices and Incomes Board. The moral problems which face Mr. Aubrey Jones now face those whose guiding principle for many a decade was that social benefits, whatever they may be, and however much they may cost, must be applied universally.

But where did the idea of Universalism arise from? Some suggest that in the early days of the Labour Movement the poverty and atrocious living and working conditions of the working-class blinded those who championed their interests as to what the future might bring once these conditions had improved. Nor, it would seem, did they foresee that the very people they fought against, the middle and

upper monied-class, would one day benefit from their reforms. For them Universalism meant the betterment of working-class conditions.

We have apparently come now around a full circle, a circle initially drawn by those who cared only for the poor and needy. For once again those in real need of support and aid are failing to get adequate benefits and allowances.

Under the present economic conditions Universalism is a non-starter, and is in sore need of reform. Attempts have and are being made, but the banner headlines—Means Test—and the memories it conjures up of the vicious and evil results it caused in the 'thirties make these reforms difficult for many to accept.

The controversy has lately hit the Health Service, where certain persons suggest that patients should help to pay for their treatment under the N.H.S. In support of their arguments they refer to the growing movement towards disparate benefits in other social services. However, the policy of the Government recently stated by the Minister of Labour, although expressing the case for a differential distribution of cash or subsidies to aid the poor, in no way implied that patients should pay in whole or in part for their treatment; "Is there no case for concentrating what we have available on those in the greatest need?" The question, though rhetorical, is essentially a statement that there is in fact a case, but the defined need to mitigate poverty is very different from the undefined and unpredictable need for medical treatment which may befall anyone, rich or poor.

The suggestion that charges should be imposed, for example, on prescribed drugs or consultations, is deplored because they would penalise patients—and penalise them unequally—and tend to prevent those who need treatment from seeking it.

In considering the future policy of the other social services such as pensions, family allowances, housing, the dictum "to each according to his needs" although seemingly arbitrary when put into practice may well prove far more just and fair than the universal system which has obviously failed in the past.

In so far as the N.H.S. is concerned, however, the only fair way is to leave the main burden squarely where it now resides—general taxation. That is, the concept of Universalism should remain in respect of a National Health Service.

GUY'S DIARY

SEPTEMBER

25th	M	1.00	Clinical Lecture. Prof. G. CRIKELAIR, Presbyterian Hospital, Columbia University, U.S.A. "Current Problems and Concepts in Plastic Surgery."
26th	Tu	4.30	Department of Dermatology, Anatomy Theatre. Films: (1) "A New View to Corticosteroid Action." (2) "Syntex Bio Assays."
29th	F	1.00	Clinical Lecture. Dr. HOUSTON and Department of Medicine. "Selected Cases."

CURRENT MEDICO-LEGAL PROBLEMS

I. ABORTION LAW

The present Law on medical termination of pregnancy has existed since 1861 when the Offences against the Persons Act made it unlawful for a woman to interfere with herself, if she was pregnant, or for anyone else to interfere with her thinking her to be, by administering or taking any substance or using an instrument or any other means *with intent* to procure a miscarriage, or for anyone to provide such means to a woman with the same intention. It did not then matter to the law whether there were sound medical reasons for taking such a step; no provision was made in the first instance for terminating a pregnancy which menaced a woman's life or health, and it was only later, under the Infant Life Preservation Act of 1929, that a clause setting out permission for destruction of the viable foetus—if it was done "in good faith and for the preservation of the life of the mother"—was assumed in practice to permit medical abortion in certain circumstances.

THE BOURNE CASE

Mr. Aleck Bourne, the notable obstetrician, dissatisfied with the law, deliberately aborted a girl of 14¾ years in St. Mary's Hospital in 1938 and reported the facts to the Police for action. The girl was said to have become pregnant as a result of an assault by a guardsman in Hyde Park Armoury Barracks, and Mr. Bourne had made it clear that he had taken this step in order to publicise the fact that even if rape or incest had forced a pregnancy on a girl it was not strictly lawful to relieve her of it. This defence was dropped on legal advice at the Old Bailey trial. Mr. Justice McNaghten invited the Jury to decide that Mr. Bourne had not committed an offence at law because he had, as his Counsel pleaded, terminated that pregnancy on the grounds that its continuance was a menace to the mother's life: the Judge told the jury "it may be that life depends upon health" and he made it quite clear that he included mental health. To continue a pregnancy which was likely to wreck a girl's mental health was, in

his view, sufficient to justify its termination. Mr. Bourne was acquitted—his repute untarnished.

The whole situation remained unsatisfactory, nevertheless, for many doctors took advantage of this "case law" decision, and felt it necessary only to call for the opinion of a psychiatrist for authority to terminate pregnancy. Physical grounds became less and less important and it became known that certain doctors were lending themselves to abortion practices on very loose terms. The famous Bliss and de Caux cases revealed a part of this iceberg, and it was clear that the Bourne case had, if anything, opened the door to a most undesirable practice. I saw another case in which a girl was told by a doctor to be found by her mother with her head in a gas oven (whether or not the gas was on didn't matter for the medical report) whereupon a psychiatrist would certify that she was suicidal and must have her pregnancy terminated. In another series I helped to deal with, a Police Officer spent many hours up a tree keeping watch on a nursing home in Bucks where girls came and went with astonishing rapidity for those in need of nursing home treatment and where enquiry showed the matron had no qualifications: prosecution in this instance failed.

DEVELOPMENT OF NEW ATTITUDES

Such loose ethics were bad for reputable doctors, and those who would not listen to pleas from distraught girls or their mothers were regarded as old die-hards, reactionaries, and "out of touch with modern medicine". An Inter-Departmental Abortion Committee which sat in 1939 under the chairmanship of Lord Birkett found that the practice of criminal abortion was rife in most cities in England. Though the exact figures were extremely difficult to ascertain because of the natural reluctance of women to admit, when hospitalised or questioned, what had taken place, it seemed likely that not less than 40 per cent of the 1 in 5 of all pregnancies which ended prematurely were the result of an unlawful interference. This figure meant that perhaps 300 to 400 unlawful abortions took place every day in England and Wales alone, yet only 40 to 50 prosecutions appeared in the Court records.

Recommendations were embodied in this Birkett report but its terms of reference did not entitle it to change the law, so it lay on the shelves as no more than an interesting document. One of its recommendations, lawful medical termination of pregnancy, was authorised in Russia and Japan and in Sweden but no such facilities were offered in this country, and increasing unrest was felt because no one took any steps to modernise the law. It was a curious fact that the mortality of legalised or therapeutic abortion was generally higher (around 0.7 per cent) that that of "back street" and "black" abortions—perhaps only 0.3 to 0.4 per cent.**

Professor Baird of Aberdeen had already started to take a strong personal attitude about the medical and social interpretation of "life

**Both are substantially less than the mortality in multiparity.

depending on health" and it became well known that the practice in terminating pregnancy in Aberdeen was a good deal more liberal than in most other parts of the British Isles. Parliament had eventually to take notice of a situation which was changing so rapidly, and in 1965 Lord Silkin introduced a Bill into the House of Lords which proposed a radical reform in abortion law, permitting termination of pregnancy for a wide variety of social and economic as well as health reasons. It was strongly opposed, criticised in such detail and at such length as eventually resulted in its being abandoned.

THE DAVID STEEL BILL

Mr. David Steel, the Liberal Member for Roxburgh, achieved medical support in 1966 in the House of Commons for a Bill which proposed to amend the law to the extent that termination would be permissible if two registered medical practitioners formed the view in good faith—

"(a) that the continuance of the pregnancy would involve risk to to the life or of injury to the health or well-being, whether physical or mental, of the pregnant woman, whether before, at, or after, the birth of the child; and in determining whether or not there was a risk of injury to health or well-being, account might be taken of the patient's total environment; or,

"(b) that there was a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped; or

"(c) that the pregnant woman's capacity as a mother would be severely overstrained by the care of a child or of another child; or

"(d) that the pregnant woman was a defective, or became pregnant while under the age of sixteen, or became pregnant as a result of rape"

—it would be proper to terminate the pregnancy. (The exclusion of pregnancy by incest was a curious omission.)

The Bill aroused much interest and it was not long before the Abortion Law Reform Society, the British Medical Association, The Medical Women's Federation, the College of Obstetricians, and other bodies submitted memoranda in the hope that the proposals would become law, if only in a modified form. As regards the essential safeguard of obtaining the opinion of two medical practitioners, it was pointed out that certain conditions were essential. These were (a) professional consultation between doctors of acceptable status and (b) the abortion would have to be done in a reputable (perhaps registered) place, not just any old nursing home as had so often been the practice. This alone caused a great deal of trouble, for many family doctors were found to have strong views about the termination of pregnancy and were not prepared to give their assistance in such a project, whether on religious or moral grounds it did not matter.

Then it was realised that the G.P./Specialist consultation, though desirable involved a decision about the professional status of the obstetrician: must he be a consultant, or would a registrar do? Weren't many doctors as well informed about such matters as young registrars, and did it matter whether they held a National Health Service post or not? Was it not safer to have a second consultant or would this make a procedure unwieldy? Then was it reasonable to insist that the procedure itself should be conducted by a consultant and no less? Would not many consultants themselves be disinclined to accept such a practice as a National Health Service obligation? Would the G.M.C. stand by them in their decisions to help or not to help? Should the procedure be notifiable and, in the event of death, should the coroner be informed as a routine? Should cremation be allowed?

CURRENT PROGRESS

All these difficulties provided so much ground for discussion that the talking is still going on, but the Commons has agreed* that the law on therapeutic abortion must be changed in order to permit the termination of a pregnancy which is not merely causing a danger to life but is a severe social or economic handicap which will seriously disturb the family harmony, and that it should obviously be possible to terminate a pregnancy which might well result in the birth of a defective child, or which had unquestionably resulted from rape or incest. General agreement among doctors is difficult enough to reach, and when it is necessary also to have an agreement of specialists in the profession, of Associations and Societies, Parliamentarians and their public, and of religious bodies of varying attitudes, it is obviously going to require much tolerance and understanding to formulate a law that will be acceptable to everyone.

Whether or not a pregnancy can be terminated is a question to be decided by doctors in the circumstances of each particular case, and the law should not seek to retard progress in the practice of medicine so long as it is consistent with the high ethical standards doctors must maintain. Liberalising law to conform with changing attitudes must always seem to make slow progress: it will be better law in the end if wisdom and care are shown in formulating it.

*_Bill_ passed on 14 July, 1967.

PRIMARY ALDOSTERONISM

— CONN'S SYNDROME —

by

ANNA-MARIA TIHANYI

The existence of aldosterone (or electrocortin, as it was originally named) was first demonstrated by Tait et al. in 1952. It is a powerful mineralocorticoid, effecting retention of sodium by direct action on the distal convoluted tubule of the nephron. It also increases excretion of potassium and magnesium, partly by direct action and partly because the kidney exchanges potassium ions for sodium ions in its presence.

The hormone is produced by the zona glomerulosa of the adrenal cortex, and its rate of secretion is controlled by a combination of nervous, humoral and circulatory influences, although the exact nature and relative importance of these is not yet clearly known. Normal plasma levels of aldosterone vary between 0.04 and 0.08 microgramme/100 ml.

In 1954, Professor J. W. Conn presented a paper describing a case of what he named "primary aldosteronism". This was a case wherein a secreting adenoma of the zona glomerulosa led to a recognisable syndrome. Since then, several cases have been reported and Conn's Syndrome has been accepted as a clinical entity.

Primary aldosteronism is most prevalent in the fifth decade of life. In some 85 per cent of the cases presented it is caused by a characteristic, small, canary-yellow adenoma of the zona glomerulosa. In these cases, the ratio of women to men is 3: 1. Of the remaining 15 per cent, 9 per cent are caused by bilateral hyperplasia of unknown aetiology, and the remainder by a carcinoma of the adrenal. No relative sexual variation is shown in this group.

Presenting Symptoms

The presenting symptoms may be divided into three categories:

1. Those resulting from electrolyte disturbance.
2. Those resulting from the hypertension which is a feature of the disease.
3. Those resulting from renal changes.

In the first category there is muscle weakness, with bouts of paresis or paralysis, tetany and parasthesiae, resulting from potassium depletion in the muscles. The tetany is not attributable directly to potassium depletion, and serum calcium levels remain normal. However, the

potassium loss results in an alkalosis, which reduces the level of *ionized* calcium in the blood, thus giving rise to tetany.

The second set of symptoms are those of hypertension—chiefly severe headache. The exact cause-and-effect relationship between primary aldosteronism and hypertension is not yet clearly understood. It is probably, however, concerned with renin and thus angiotensin secretion, since angiotensin has vasopressor effects and also influences aldosterone production. The hypertension exhibited in primary aldosteronism may be severe, often with diastolic pressures above 100 mm. Hg.

Renal symptoms appear early in Conn's Syndrome, but become more marked as the disease progresses, accounting for the third category of symptoms. Initially, the changes are simply the result of disturbed electrolyte balance. However, in time, the epithelium of the tubules is affected, and vacuolisation becomes apparent histologically. There is loss of urine concentrating capacity, with a resultant polyuria, leading to nocturia. This in turn accounts for the polydipsia which is one of the presenting features of Conn's Syndrome.

In summary, then, the patient presents with muscle weakness, paresis of varying degree, headache, polyuria and polydipsia.

Clinical and laboratory findings

Clinically, positive Chvostek and Trousseau signs may be elicited.

Laboratory examination will reveal the following:

Blood:

Hypokalaemia. Plasma potassium levels may fall from a norm of about 4.0 mEq./100 ml. to below 2.0 mEq./100 ml. Since potassium is predominantly an intracellular ion, this is merely a reflection of the grosser changes taking place within the cells, especially muscle cells. As a result of potassium depletion, there is a systemic alkalosis and the pH of the blood rises.

E.C.G. will show the typical long, low QT tracing of hypokalaemia.

Hypernatraemia: Although patients with Conn's Syndrome show a tendency towards hypernatraemia, this is not as marked as might be expected in view of the fact that aldosterone in primarily a sodium conserving agent. However, about 80 per cent of sodium reabsorption takes place in the proximal convoluted tubule, so that aldosterone only affects the 20 per cent which reaches the distal tubule. In addition, it has been suggested that there is a renal "escape mechanism" which allows sodium to be excreted, after it has reached a certain level in the blood, despite high aldosterone concentrations. The nature of this mechanism is unspecified.

Urine:

1. Polyuria, as described above.

2. The urine contains large concentrations of potassium, despite the low serum potassium. It also contains relatively low concentrations of sodium, due to the direct action of aldosterone.

3. It is alkaline, as a result of the generalised alkalosis.

4. There is albuminuria, increasing with the length of time the disease has been in progress. This is believed to be simple leakage from the damaged kidney tubules.

5. Urinary aldosterone levels are greatly raised. However, the concentrations of 17-ketosteroids and 17-hydroxycorticoids are normal showing that there is no pituitary malfunction, and the lesion is localised in the zona glomerulosa.

Saliva:

There has been a great deal of interest in salivary (and sweat) sodium : potassium ratios. However, these have proved of theoretical rather than practical importance, since the ratio shows much variation amongst individuals, and in different circumstances. Nevertheless, in any given patient, the salivary sodium : potassium ratio reflects the hormonal situation i.e. sodium retention, potassium loss. Thus, concentration of sodium in the saliva drops, while that of potassium rises, so that the ratio is correspondingly reduced.

Diagnosis

Diagnosis of Conn's syndrome is not easy, as the presenting symptoms may be associated with many conditions, and the estimation of blood aldosterone levels is extremely difficult. The main lead is usually the marked hypokalaemia.

At this point, distinction must be made between primary and secondary aldosteronism. Secondary aldosteronism follows on congestive heart failure, cirrhosis of the liver, and toxaemia in pregnancy. All these conditions give rise to marked oedema. It is noteworthy that in primary aldosteronism, there is no oedema.

Once hypokalaemia has been established, the following features may be of diagnostic value:

The hypokalaemia is resistant to potassium replacement therapy. The more potassium given, the greater the loss in the urine, with only a very slow rise in serum potassium levels. This is probably because the cells have established an abnormal ionic equilibrium, which would be upset by the absorption of the added potassium.

There is a persistent alkalaemia, which is hardly altered by administration of ammonium chloride.

Spironolactone may be given as a diagnostic measure, although it is not to be regarded as absolutely reliable. It is a competitive antagonist of aldosterone, and will thus abolish the symptoms produced by the hormone. It has been found that spironolactones inhibit aldosterone for some 12—20 days, during which time a normal electrolyte equilibrium is regained and the patients are symptom-free. However, spironolactone appears to lose its inhibitory effect, and the

symptoms return. Its value, therefore, is chiefly in establishing that aldosterone is, in fact, the cause of the symptoms.

Treatment

Since neither spironolactone nor potassium replacement therapy is effective, treatment is surgical. Both adrenals are exposed, and the tumour removed if present. If no tumour is visible, bilateral subtotal adrenalectomy is performed.

Usually, electrolyte balance is re-established almost immediately after surgery, and renal symptoms also disappear quickly. Hypertension is almost always reduced, although this may tend to persist after the other symptoms have disappeared. In the majority of cases, cure is complete or near-complete.

REFERENCES

C. L. Cope: "Adrenal Steroids and Disease" (1965).
J. W. Conn and L. H. Louis: "Primary Aldosteronism a new clinical entity". Annals of Internal Medicine, Vol. 44, 1956.

MUSIC

WAGNER—DER RING DES NIBELUNGEN

Just about this time of year, the few lucky people who have purchased tickets by sleeping outside Covent Garden for one or two nights assemble to hear Wagner's immortal music drama. There are four operas, of which "Das Rheingold" forms the prelude to the other three—it runs for a mere $2\frac{1}{2}$ hours. The other three run for at least four hours each and are in sequence: Die Walkure, Siegfried and Götterdämmerung. As far as Covent Garden is concerned, these start at 6 p.m.; as at Bayreuth at least one cycle is completed in one grand week.

Many are bitten by the "Ring" craze, sufficient for the Vienna Philharmonic/Solti/Decca complete recording to be a best seller and for D.G.G. now to be mounting their own complete recording with the Berlin Philharmonic under Herbert Von Karajan. The latter is said to be filming it also!

In an article of this nature one cannot hope to give an account of the action of 17 hours' opera, but more an idea of the fascination it holds. This is, to me, more than just opera: it is true DRAMA. Prior to this series, Wagner considered opera "a means of expression—music, has been converted into the object and that the real expression, drama has been converted into the means". Ernest Newman summed up Wagner's great advance when he wrote: "his case is unique in the history of art . . . each of his characters, each of his situations has been created by the simultaneous functioning within him of a composer's imagination, a dramatist's, a conductor's, a scenic designer's, a mime's. Such a combination has never existed in a single individual before, it has never happened since and it is probable that it will never happen again." Clearly, then, productions need time, money, singers capable of physically acting and conductors capable of thinking just beyond the scope of the orchestral parts to bring off many of Wagner's complex stage directions.

For this purpose, the opera house at Bayreuth was specially built to Wagner's specification and the first performance of the completed work was given in 1874. In the original production, Rhinemaidens had to swim, serpents and dragons had to appear, steer horns had to be blown, horses had to be on stage, including one that had to be ridden straight into the funeral pyre in Act III of Götterdämmerung. In our productions today we should frown where Wagner's meticulous directions are not followed.

In the old days, lavish sets were used with much colour, grand costumes and brilliant lighting—the whole had a majestic aura. At Covent Garden we now have a dull set—for Rheingold and Walkure just a central round halo. However, Bayreuth has gone one worse—the whole performance is in almost complete darkness—this at the direction of Wieland Wagner, the composer's grandson.

For me, the great fascination of the Ring lies in the vast musical panorama. The whole is based on single themes met in Rheingold and these become increasingly elaborated as the cycle continues. One can enjoy it, understanding no German, as a vast symphony. Soon even this difficulty is to be removed as Covent Garden are mounting their new 1969 production in English, directed by Peter Hall (of Stratford on Avon fame).

We have been very lucky with the conductors at Covent Garden. Gustav Mahler (the great composer) conducted the premiere in 1894. More recently the annual conductor has been Furtwangler, Kempe and Kubelik. Now Mastro Solti and Edward Downes do the honours. People may criticise Solti's reading for being brash and brassy, but his sheer enthusiasm and ability to get really outstanding orchestral sound are at least some compensation.

For the uninitiated, beg, borrow or better still, buy side 12 of the Götterdämmerung recording and see if you still feel this is the dull monotony that you feared!

HEDLEY BERRY

QUIZETTE : Endocrinology

A. Diabetes occurs in:
(1) Acromegaly; (2) Thyrotoxicosis; (3) Pluriglandular syndrome, etc.; (4) Insulinoma; (5) Cushing's syndrome.

B. Absence of diurnal serum cortisol rhythm may occur in:
(1) Congestive cardiac failure; (2) Obesity; (3) Christmas disease; (4) Cushing's syndrome; (5) Stress.

C. Ca. bronchus has been shown to produce the following endocrine syndromes:
(1) Cushing's syndrome; (2) Hyperparathyroidism; (3) Acromegaly; (4) Gynaecomastia; (5) Dilutional hyponatraemia; (6) Diabetes insipidus.

D. Expanding pituitary tumours may occur:
(1) After adrenalectomy for Cushing's syndrome; (2) With acromegaly; (3) With thyrotoxicosis; (4) In pituitary acropachy; (5) In long standing Addison's disease.

E. L.A.T.S. may be found in the serum of:
(1) Babies of mothers with treated thyrotoxicosis; (2) Babies of mothers with thyrotoxicosis; (3) Myxoedema; (4) Exophthalmos without thyrotoxicosis; (5) Pretibial myxoedema.

F. Hashimoto's disease is:
(1) More common in men; (2) Rarely associated with a goitre; (3) Always preceded by thyrotoxicosis; (4) Frequently associated with the L.E. factor; (5) Treated with corticosteroids.

G. Carcinoma of the thyroid:
(1) May be caused by therapeutic radio-iodine in adults; (2) May follow D.X.T. to neck in children; (3) Carries a better prognosis in elderly patients; (4) Frequently associated with toxic adenoma; (5) Often treated with radioactive I-131.

H. The treatment of myxoedema coma includes:
(1) Corticosteroid therapy; (2) Thyroid extract; (3) Rapid re-warming; (4) Bemigride; (5) Hot sweet tea; (6) Liothyronine.

I. Myxoedema may cause:
(1) Ataxia; (2) Hypertension; (3) Pericardial effusion; (4) Deafness; (5) Psychosis

J. In thyrotoxic heart failure:
(1) Digoxin is of little value; (2) Propranolol is dangerous; (3) Diuretics do not work; (4) Cardioversion is treatment of choice; (5) There is Bradycardia.

K. Thyrotoxicosis may be associated with:
(1) Gynaecomastia; (2) Osteoporosis; (3) Hyperphosphaturia; (4) Myopathy; (5) Diplopia.

L. Diabetes insipidus is:
(1) May be caused by pancreatitis; (2) May be treated with diuretics; (3) May be precipitated by treatment of anterior pituitary insufficiency; (4) Can be associated with Pulmonary Infiltration; (5) Is sometimes of renal origin.

M. Addison's disease may be:
(1) Associated with hypothyroidism; (2) Associated with anti-adrenal antibodies; (3) Treated with 9α flurohydrocortisone alone; (4) Caused by histoplasmosis; (5) Fatal.

N. Hirsuitism may be feature of:
(1) Congenital adrenal hyperplasia; (2) Simmond's disease; (3) Cushing's disease; (4) Stein Leventhal syndrome; (5) Adrenal carcinoma.

O. Hypercalcaemia occurs in association with:
(1) Sarcoidosis; (2) Hyperparathyroidism; (3) Vitamin D poisoning; (4) Acute renal failure; (5) Tetany; (6) Thyrotoxicosis.

P. Calcitonin:
(1) Originates in parathyroid; (2) Originates in thyroid; (3) Originates in thymus; (4) Causes hypocalcaemia; (5) Is a polypeptide; (6) Is important therapeutically.

Q. Growth hormone is:
(1) Successful in Hyposomatotrophic dwarfs; (2) Successful in Turner's syndrome; (3) Sometimes inhibited by antibody production; (4) Useful in untreated Cretins; (5) Released in response to hypoglycaemia.

QUIZETTE ANSWERS

A **1, 5.**

B **1, 2, 4, 5.**
This fact may make the exclusion of Cushing's syndrome difficult but all should suppress with dexamethasone.

C **1, 2, 4, 5.**
These syndromes are due to secretion by the tumour of polypeptides having actions similar to ACTH, ADH etc. For a good summary see Hospital Medicine, October 1966.

D **1, 2.**
After adrenalectomy this occurrence may be associated with sudden generalised pigmentation.

E **1, 2, 3, 4, 5.**
For a good summary of the present position read, Modern Trends in Endocrinology, 1967.

F **None of these.**

G **2, 5.**
Carcinoma has never been shown to be caused by I-131, unlike D.X.T. to the neck region in children. Carcinoma is more often associated with a cold non-functioning nodule.

H **1, 6.**

I **1, 2, 3, 4, 5.**
Ataxia is the most recently recognised, Brit. Med.J. (1967) II, 5550 456.

J **1.**

K **1, 2, 3, 4, 5.**
For a good study of calcium metabolism in thyrotoxicosis see Adams Quart. J. Med. (1967) 36, 141.

L **2, 3, 4, 5,**
The pulmonary infiltration may be due to sarcoidosis or Histiocytosis X. .

M **1, 2, 4, 5.**
The combination of Addison's disease and hypothyroidism is known as Schmidt's syndrome. Metabolism (1967) 16, **2**, 189.
The idiopathic form of Addison's disease is associated with anti-adrenal antibodies in 80 per cent of female cases and 10 per cent of male cases. Irving. Clin. Exp. Immunol. (1967) **2**, 31-69.
Histoplasmosis may be a cause of Addison's disease in America.

N **1, 3, 4, 5.**
Hirsutism in these conditions is due to excess circulating androgens. For current views, read Prunty J. Endocr. May and June 1967.

O **1, 2, 3, 6.**

P **2, 4, 5.**
Calcitonin originates in the "C" cells of the thyroid, it has a calcium lowering effect by inhibiting reabsorption of bone. What place it has to play in pathology and therapeutics is at present unknown.

Q **1, 3.**
The only conditions in which G.H. has been shown to be of value therapeutically, are those in which a definite deficiency can be demonstrated. For current views see Modern Trends in Endocrinology.

Compiled by M. Maisey.

WILLS LIBRARY ANTIQUITIES

5. DR. SLOP

by William Hill

John Burton is usually considered to be the original of Dr. Slop in Sterne's *Tristram Shandy*. Readers of the novel will remember that, "Of all men in the world, Dr. Slop was the fittest for my father's purpose;—for he thought HIS NEWLY INVENTED FORCEPS was the armour he had proved, and what he maintained to be the safest instrument of deliverance."

John Burton was born in Colchester in 1710 and was educated at Merchant Taylors School and St. John's College, Cambridge. He also spent some time on the Continent studying under Boerhaave in Leyden and acquiring an M.D. from Rheims. He finally settled in York and remained in obstetric practice there until his death in 1771.

Burton's forceps which he describes in his book, *An essay towards a complete new system of midwifery*, 1751, were his own invention.

"I have invented a new sort of forceps, the use of which is far less prejudicial either to the woman or child and is much more commodious for the operator". Forceps, supposedly those of Burton, are in York but there seems to be some doubt about it. The ones there seem to be modifications of the old French type and differ from the shape described in his book. It would appear from the illustrations and descriptions that using them would have been difficult, to say the least of it. There are hints of this in *Tristram Shandy*. Dr. Slop tries the forceps on Uncle Toby's fist with the result that the skin is torn and the knuckles flattened. Tristram's nose was damaged and Dr. Slop tries "to make a false bridge with a piece of cotton and a thin piece of whalebone out of Susannah's stays".

It was Burton's political views which caused his persecution and Sterne's satire. The full story is too long to be told here but there is

an excellent account of it by Alban Doran in the *Journal of Obstetrics and Gynaecology of the British Empire,* 1913, vol. 23. Burton was certainly capable of holding his own in any controversy. In his preface he says:—

"But for those People, who like Birds of Night scream in the Dark, when none can see them, and like cowardly Enemies, unseen, shoot their invenomed Darts at me, in secret whispers, or anonymous Papers, such creatures may spit their malignant choler till it consume themselves, before I shall regard them in the least."

One target of Burton was William Smellie, who he criticises unmercifully, ridiculing his scholarship and his ability. He wrote a book, 233 pages long, described as *A letter to William Smellie, M.D.— Containing critical and practical remarks upon his treatise on the theory and practice of midwifery.* The contents page starts :—

> "Proved that Smellie (or the Person he copies from) has never read the authors quoted, never understood them, or wilfully misrepresented their meaning."

There is no false modesty about Burton. In his *Essay* he writes: "I then told the Surgeon who was with her, that as he had been first sent for, I would compliment him so far, as to give him another Opportunity of delivering her, but he declined it, saying he could not do it. I then prepared myself, and giving my Watch to one of the By-standers, I desired her to observe how long I should be in delivering the Patient; and then begun, and delivered her of the Child, and fetched the After-birth also, in less than half-a-minute by the strictest Observation. How the Surgeon and the By-standers looked at each other in Amazement, is easier to be imagined than expressed."

Burton should not be remembered either by his failings or by Sterne's satire. He had a high reputation in his day and was remembered as an obstetrician who rode the country around York attending country-women. He was also justly critical of Smellie over his forceps. Smellie advocated covering the blades with leather. Burton's answer was "some part of the blood and waters must be sucked up by the leather, and lodge betwixt it and the steel, where it will corrupt and stink."

He was also the first man to suggest that puerperal fever was contagious, twenty years before Leake and nearly a century before the work of Holmes and Semmelweis.

As usual, the books mentioned in this article will be on display in the Wills Library for the next fortnight.

CORRESPONDENCE

Food and the College

SIR,—Your readers may be interested to know a little of the history of the birth of the College Catering Committee in 1927.

One discovered, when student assistant secretary of the Students' Club, that the rent paid to the College Committee for the use of the Spit, Pavy Gym and library was based on a *per capita* of its membership—probably a fair rent in 1914 (membership about 400), but excessive with some 900 after 1919.

Over the years two mass meetings of students, held in the overcrowded physiology theatre, had sent catering protest resolutions to the College Committee with negative results. With these defects in mind, one was able to persuade Mr. E. C. Hughes, Secretary of the College Committee, of the need for a new tenancy agreement which would include a fixed rent and the establishment of a Catering Committee with equal representation of the College Committee (staff) and students, with the Hospital Treasurer as chairman.

Mr. Hughes also sanctioned the payment of a fee to Mr. Syd Price, manager of Holborne Stadium Club, to examine and report on the College catering. He expressed the view that, with improved equipment, an efficient manager could provide better meals and a profit.

This was supported by a visit to Bart's where catering satisfaction and profits co-existed.

There was much advice in Mr. Price's report, which included that on how to appoint a catering manager and to avoid the risk of the manager leaving the College Committee to pay large sums to suppliers after his hurried disappearance.

This had happened on at least two previous occasions and resulted in the College Committee appointing outside caterers to avoid any further financial losses.

It was with satisfaction after leaving Guy's one heard the new tenancy agreement had been executed, the Catering Committee formed, the A.B.C. sacked and a £300 profit handed to the Pavy Gym for re-decoration and re-equipment as a result of the first year's work of the Guy's Catering Committee. Now there is further satisfaction to read on page 468 of the last *Gazette* that the next nine years were free of printed criticism.

Yours, etc.,

STANLEY P. MEACOCK

6, Eaton Road,
Coventry.

The College

SIR,—The current *Gazette* will be preserved by many Guy's men with memories of the College.

The College was unique and opinions regarding it were varied. Prior to my entering Guy's some dozen relatives and friends with experience gave their advice to me.

1. That there was a warm and friendly atmosphere at Guy's.
2. *Not* to live in the College permanently.

Both of these I appreciated and acted on them beneficially.

In the 1920's I found that the Spit gave me good value, better than I could get thereabouts. When it came to "Surgical take" I was quite content to take a comfortable, creaky bed in a bare room in the College, get a reasonable meal on awakening, be surrounded by genial people and get on with clinical work. Aged as I am (60) and with invading wood-worm, I really did enjoy it.

In no way must this letter be read as a homily. I merely record my feelings of the past. But I *do* remember with the greatest affection our "Surgical take",

our cooking and eating of sausages and the intake of beer from our three-handled sconce, filled I think from the "Miller".

Yours, etc.,

D. S. HAYTON-WILLIAMS

Department of Oral Surgery,
Churchill Hospital,
Oxford.

Dental Ancillaries

SIR,—By admitting he is a student and not versed in the problems besetting the general dental practitioner, Mr. Lambden cannot understand the fears in the minds of qualified colleagues.

He mentions that no differentiation is needed between the dental surgeon and auxiliary.

Is he aware that even now these ladies are referred to as "dentists" by the general press?

Can the public distinguish between a dentist and a "dentist"?

There was previous correspondence in the *Gazette* on this topic, and after a challenge by me, I am happy to remind readers that the secretary of the British Dental Association pledged his Association to fight any extension of the remit of these ladies, any relaxation of the rules governing supervision, and even to allow perhaps male ancillaries to work on adults.

This is the real problem facing our profession Mr. Lambden, the danger that with the inception of these ancillaries, the profession might find this "experiment" to be the thin edge of the wedge.

Yours, etc.,

L. B. LUX
Assistant Secretary
General Dental Practitioners' Association.

Flat 2,
Heatherlea, Prescot Road,
Hale, Cheshire.

Any Old Teeth?

SIR,—Your dental readers will probably be aware that the Dental Curriculum is being changed this autumn. One of the effects of this change will be to bring Phantom Head Teaching forward by about 9 months. During the transition period we shall have very large Phantom Head classes.

I am therefore appealing to Guy's Dental Surgeons to save all teeth they extract and to send them to me. Considerable publicity was given recently to the fact that 10 tons of teeth are extracted annually in this country, so it is ironical that we find difficulty in obtaining enough teeth for training students. I estimate that we require about 9lbs. weight of teeth per year!

Following extraction the teeth should be placed in an antiseptic solution. Dried teeth are of little value as they fracture during cavity preparation.

All contributions, large or small, will be gratefully acknowledged. Suitable containers will be supplied on request.

I should like to take this opportunity to thank all those who have been sending us teeth over the past years.

Yours, etc.,

A. H. R. ROWE

Dental School,
Guy's Hospital.

H.O.P.

SIR,—It is about time some action be taken to improve conditions at H.O.P. Grounds, building and facilities all need drastic measures to prevent total collapse of any interest in sport at Guy's .

The Club House is appalling, it is an eyesore outside, and a lower-class slum inside. The changing-rooms are disgusting. Apart from throwing out the two hundred odd boots "stored" on top of the lockers, a new floor would prevent the accumulation of multiple splinters in the feet after changing at H.O.P. The baths are old-fashioned and the showers inadequate; they need both modernising and enlarging.

Little need be done to the rest of the building except for a re-paint and general overhaul. That is until the hole in the wall which is a ludicrous apology for a bar is considered. With the re-planned grounds, it will now be possible for 133 people plus spectators to be demanding refreshments at about 5 o'clock on a Saturday. The bar ought to be enlarged considerably to cope with this thirst.

Due to a lack of staff, there has been curtailment of many facilities. So far this year, there have been no towels provided after training sessions. Similarly, three weeks in August were spent enjoying the spartan delights of cold showers. There have also been several complaints of inadequately prepared pitches. Indeed, several students have done quite a lot of work on the grounds this summer. A full complement of staff should be employed all the time.

The teas provided for visiting teams are almost adequate for those travelling only a short way. Those who have travelled a long distance would, I am sure, appreciate something more substantial after a match. To provide a full meal would require improved kitchen facilities and an extra helper for a Saturday afternoon.

There has been much talk recently of major change at H.O.P. and even a committee decision has been made to this effect. However, nothing has yet been done. Why not? Certainly not from lack of money; thousands of pounds must have been saved from reducing the staff and not spending any money on upkeep in the last twenty years. I think a more positive and interested attitude by members of student and staff bodies associated with the ground at H.O.P. might at last produce some results.

Yours, etc.,

I. M. MORRIS

East Wing,
Guy's Hospital.

Dr. J. D. S. Thomas

SIR,—May I add to P.J.L.'s tribute that our contemporary represented Guy's Boxing Club in the inter-hospital annual events, in a few friendly visits to the University of Cambridge and Oxford (where his brother J. G. S. Thomas was a boxing half-blue) and finally in the Public Schools, Cadets, Universities and Hospitals tournament. His unbeaten record as a featherweight justified Eugene Corri's opinion and Guy's for promoting him from half-blue (awarded 7/9/20) to be the first full-blue for Boxing ever awarded at Guy's.

Unable to confirm this in my search through the *Gazettes* 1920-25, I hope the evidence can be found in the Minutes of the Blues Committee and the Clubs' Union, which body usually approves blues awards.

Memories are fickle and I feel sure J. D. S. Thomas would wish it to be stated that although he played much rugger he did not play in the 1st XV so far as my memory serves me, and I may have to apologise to P.J.L. if in fact this statement is incorrect.

Yours, etc.,

STANLEY MEACOCK

6, Eaton Road,
Coventry.

Bring and Buy Sale

SIR,—Last Christmas a Bring and Buy Sale organised by the Teachers was held in the Department of Paediatrics. The object was to raise money to send medical supples to Dr. Philip Evans in Saigon and about £100 was collected. I am glad to be able to report that through the generosity of the Pharmaceutical Industry Dr. Evans received drugs worth many times this sum.

The fund was used to cover the cost of transportation to Vietnam, which was arranged by the Crown Agents through the Ministry of Overseas Development. I am most grateful to everyone concerned with this and in particular Beecham Research Ltd., Park Davis & Company, Imperial Chemical Industries Ltd., and The Wellcome Foundation Ltd.

Yours, etc.,

M. D. O'BRIEN

Department of Medicine,
Guy's Hospital Medical School.

Pharmacy

SIR,—The system that Mr. Moore outlines is excellent, but unfortunately it was never in use when I attended the dispensary. My records will show on which dates I was at Guy's. Since my letter the service has been faultless.

Yours, etc.,

ELIZABETH KIERAN

54, Parkside,
Vanbrugh Park,
London, S.E.3.

Toscanini

SIR,—Toscanini's first name was Arturo not Antonio. Mr. Berry should celebrate a centenary with a correct name.

Yours, etc.,

ALEX WENGRAF

162, Langton Way,
Blackheath, London, S.E.3.

[EDS. *So he was and shall be. Apologies from our Music correspondent.*]

OBITER DICTUM

B–LL H—LD

Talking to a travelling salesman who has just presented him with an "Applicator": "I'm not a gynaecologist, but I occasionally find myself in vagina by mistake."

REVIEWS

A SHORT TEXTBOOK OF GYNAECOLOGY AND OBSTETRICS

G. D. Pinker and D. W. T. Roberts E.U.P. *Price* 16/-

This short and cheap book is amazingly complete. In only 180 pages of text all the essential aspects of gynaecology and obstetrics are covered and nothing of any importance has been left out. It provides a good account of both subjects in a brief and pleasent readable manner.

The book is made attractive by being splendidly up-to-date, by being written in a clear and lucid style and by avoiding controversy. The approach to gynaecology, by dealing with it from the point of view of presenting symptoms, is quite refreshing.

Of course, in a book of this sort one can always argue about the relevant emphasis given to different aspects. Here, the brief discussions on neo-natal resuscitation and maternal diabetes for example are out of all proportion to the space given to uterine inversion, to fistulae and in particular to gynaecological operations. These have a full chapter in addition to the comments made about them in discussing the management of individual gynaecological conditions.

A little more on cytology, pessary management and catheterization would be helpful. A discussion on the common drugs used in gynaecology (perhaps arranged as an appendix giving names and dosage schemes) would have added to the book's value without increasing its length disproportionately.

Some of the drawings unfortunately suffer from being pictorial rather than diagrammatic and in some cases appear rather crude (prolapse), inaccurate (brow presentation), and naive (transverse presentation). The attempt at expressing x-ray appearances of types of pelves does not succeed as well as it might. However, all these are minor points of detraction.

The book is ideal in providing an introduction and overall assessment of these subjects for the widely read student; it is quite excellent for revision purposes. It also gives the basic reading for the student who cannot handle a large textbook. It would also provide a convenient means of extended reading for student nurses and pupil midwives. On these counts and with its very reasonable price this book well deserves recommendation.

PATRICK TATFORD

COMMON SYMPTOMS OF DISEASE IN CHILDREN

by

R. S. Illingworth, 1967. Blackwell Scientific Publications. 270 pages. No illustrations. 40s.

It is difficult to review such a boring book; yet tediousness does not preclude it from being useful.

A hundred common paediatric symptoms are presented and dealt with mainly in the form of lists: there is a minimum of discussion. Diagnostic lists are the scaffolding on which many of us work. They are enjoyable to compile from reading and experience, become trusted allies and a source of pride, and eventually a source of vague resentment when on passing them on to students the audience is completely unimpressed. That is the fate that awaits some of the lists in this book, several would have been better omitted, for instance, the twenty-six all organic causes of abdominal pain (the 26th is porphyria). However, many of the short sections are admirable and deal with such topics as head asymmetry and neonatal cynaotic attacks, symptoms that are poorly documented and rarely indexed in text books. General Practitioners and paediatric staff are likely to find many of the sections useful, though even extensive modification is unlikely to make this book as popular as some of Professor Illingworth's excellent books. It is not recommended for students.

In his preface the author writes that he started the book because he knew of no other concerning the common symptoms of disease in children. Fortunately his publishers knew better and on the dust jacket advertise the second edition of " The Child and his Symptoms " by Apley and MacKeith. (It was that book which, to my everlasting surprise, proved to be more useful than any other book during my time in general practice.)

S. R. MEADOW.

NURSING SECTION

A synopsis of a report on the Third Sponsored Exchange Visitors' Programme by The Clothworkers' Guild to the Johns Hopkins Hospital, Baltimore.

Through the generosity of the Clothworkers' Guild, I spent a most rewarding, interesting and amusing year in America.

I duly arrived at Baltimore and The Johns Hopkins. Baltimore is situated in Eastern Maryland, on the Chesapeake Bay; 40 miles north of Washington and 190 miles south-west of New York. The Hospital was founded in 1867 by Johns Hopkins, a merchant philanthropist. Adjoining the hospital are the Schools of Hygiene, Public Health and Welsh Library. The Library houses a famous painting by John Singer Sargent, "The Four Doctors", Drs. Welsh, Osler, Halstead and Kelly. These men were instrumental in establishing the fame of Hopkins.

I arrived at the Nurses' Residence, and from the instant warm friendliness of the first few nurses, I began to feel an "at homeness" at the Hopkins. The warm generosity and hospitality I experienced, not only from the staff of Hopkins, but from the very many Americans I met on my travels, I shall always remember with affection.

The first week was an orientation period. We visited all departments of the Hospital and spent one hour daily in the unit of our choice. I had chosen to work in the Women's Clinic, which is the Gynaecological and Obstetric Unit.

The Unit consists of 135 beds, of which 69 were Gynaecological and 66 Obstetric. There were five floors and each formed a letter "H". The first three divided into "A" and "B" sides. "A" being Gynaecological and "B" Obstetric. Each floor had a nursery and the total cot space was 66. The fourth floor being labour and delivery, also the Obstetric recovery ward. The fifth, Gynaecological operating rooms and recovery ward. All patients recovered in these units before returning to their floors. The ground floor consisted of the Radiological Department (for the Women's Clinic only), Cystoscopy rooms, lecture classrooms for medical and student nurses, also a library.

I spent equal time in all wards and departments. Firstly in the Private and Semi-Private Ward on the third floor. Private rooms were approximately £14 a day—Semi-Private £11. All drugs, investigations and surgeons' fees were extra. Most people subscribed to an insurance scheme called The Blue Cross and Blue Shield, which enabled them to receive adequate medical attention.

The average length of stay for Obstetric patients was three days, the gynaecological length varied considerably, but was very much shorter than the stay in England. Dilatation and curettage often went home the same day.

Baltimore has a very high negro population—approximately 50 per cent—and the Johns Hopkins is situated in the midst of this insurgent population. The illegitimacy rate is proportionately high. The youngest pregnant child admitted whilst I was there was 11 years old; she was delivered and intended continuing her studies whilst her mother cared for her child. The social worker would always be asked to consult with the child's family and much help was given.

The criminal abortion rate was extremely high and the Resident (Registrar) would notify the Police "Abortion Squad", who would in due course visit the patient in plain clothes and question her in private.

The student nurses received twelve weeks' experience in Obstetrics and four weeks in Gynaecology. There were six clinical instructors in the Unit. Lectures were given in students "on-duty" times. At the end of each speciality, the nurses were required to pass examinations. If proficient at the completion of their third year, they received their Diploma of Nursing.

The nurses did not receive a salary during their training. The total cost of their three year training was £450 and all textbooks, etc., were also paid for by the nurses.

Medical Staff Residents, Assistant Residents and Interns commenced their day at 7 a.m. Most days they received the night report with the on-coming day nurses. Each day at 7.30 a.m.—simultaneously—gynaecological and obstetric ward rounds would be done, commencing on the first floor and working upwards, through the unit. Drug changes, treatments, etc., would then be written up in the "Doctors' Order Book", in turn, this would be transcribed by the ward clerk, on to the Kardex.

My visits were to Atlanta, Georgia, and the Grady Memorial Hospital; a vast old hospital which is undergoing renovation. This hospital is completely duplicated. When segregation was enforced there was a complete section each for white and negro patients; even to all the equipment being separated and duplicated.

The Kentucky Frontier Nursing Service at Wendover, Kentucky, covering an area of approximately 600-700 miles of rugged, mountainous countryside. This service was founded by Mary Breckenridge. Originally, the nurses visited their patients on horseback, but now they are provided with jeeps. The nurse midwife here has a very comprehensive training of nine months and is acceptable by the Royal College of Midwives for England and Wales. The Matron-in-Charge and Sister Tutor were both British graduates.

I then visited various hospitals in Texas and my last visit was to the Medical Centre at Houston. Situated in over 134 acres of beautiful countryside. There are over 16 major institutions located in the Centre—I visited the M.D. Anderson Hospital and Tumour Institute devoted to research and treatment into malignant and allied diseases—300 beds.

J. S. PARRY,

Sister lately in Charge "D" Floor Nuffield House.

Comment by a visiting foreign Nun on seeing one of the new nurses' bedrooms: "What a charming cell!"

Sir Ivor Julian Award

There were 108 entries in a recent competition devised to produce ideas from nursing staff to increase the patients' comfort. This was open to all nurses and nursing auxiliaries working in hospitals in the South-East Metropolitan Region. Two prizes of 20 guineas each were awarded to Miss D. Pitfield, a nursing auxiliary from Pembury Hospital, and Miss J. Bell, ward sister at St. Bartholomew's Hospital, Rochester; whilst a second prize of 10 guineas was awarded to Miss Lydia Rogers, who has worked at The Dunoran Home for over eighteen years as a nursing auxiliary.

Miss Rogers' entry was a short canvas stretcher designed for lifting patients from a wheelchair into a car, or from a vehicle back to a chair.

The organisation of the competition ensured that both the name of the hospital and the entrant was unknown to the judges.

The awards were made personally by Sir Ivor Julian, C.B.E., the Chairman of the South-East Metropolitan Regional Hospital Board, on 26th July, in the Board Room of Guy's Hospital, after which the three entrants met to congratulate one another and to share the details of their respective ideas.

The most effective product for treatment of hypersensitivity has a 90% success rate.

That product is Sensodyne

Sensodyne is a toothpaste especially produced for the adjunctive treatment of dental hypersensitivity and oral neglect. Used in the same way as regular toothpaste, therapy becomes a normal everyday habit. And as regular treatment continues, so discomfort is relieved. Sensodyne tastes pleasant, cleans well and works effectively, because it contains strontium chloride—a therapeutic agent with a cumulative desensitising action. Regular use of Sensodyne results in painless brushing, improving oral hygiene, and aiding dentists to carry out speedy, unhindered treatment. Advise patients to brush with Sensodyne every day—preferably twice a day for best results.

PROFESSIONAL SAMPLES CAN BE OBTAINED FROM:
PROFESSIONAL RELATIONS DIVISION, STAFFORD-MILLER LTD.,
166 GREAT NORTH ROAD, HATFIELD, HERTFORDSHIRE.
"QUALITY PRODUCTS FOR DENTAL HEALTH."

SPORT

RUGBY FOOTBALL

With an earlier start to the season, Guy's played Bromley at Honor Oak Park. A pre-season training week-end at Thatchings, under the auspices of Dr. Hugh Burry, had evidently proved worthwhile.

The inclusion of Dr. Peter Peace, who has returned to the Guy's Anatomy Department, has greatly helped to maintain the strength of the second row.

Guy's fitness was evident even at this stage of the season, and once having broken the gallant defence of Bromley, Guy's ran home 11 points in the first half and a final score of 38—0. Cheeseborough and Rowlands both showed great promise for the season; the former opened the scoring from a fine dummy scissors with Price: Rowlands finished with a final match total of three tries.

Providing early season mistakes can be curbed quickly, Guy's could well beat a very strong Blackheath side next week.

GUY'S HOSPITAL RUGBY FOOTBALL CLUB

1ST XV FIXTURES 1967-68

Date 1967	*Ground*		*Opponents*
Sept. 9	H.O.P.	(3.00) ..	Bromley
,, 16	H.O.P.	(3.00) ..	Blackheath
,, 20	Cambridge	(3.00) ..	Cambridge City
,, 23	Kidbrooke	(3.00) ..	Old Askeans
,, 30	H.O.P.	(3.00) ..	Sidcup
Oct. 7	Portsmouth	(3.00) ..	United Services, Portsmouth
,, 14	Grange Road	(3.00) ..	Cambridge University
,, 21	Bedford	(3.00) ..	Bedford
,, 28	Tredegar	(3.00) ..	Tredegar
Nov. 4	H.O.P.	(11.00) ..	Old Blues
,, 4	Twickenham	(2.45) ..	England v. New Zealand
,, 11	Sudbury	(2.45) ..	Wasps
,, 18		(2.45)	
,, 25	Cheltenham	(2.45) ..	Cheltenham
,, 29	Loughborough	(2.45) ..	Loughborough College
Dec. 2	Thornton Heath	(2.30) ..	Streatham, Croydon
,, 9	Thames Ditton	(2.30) ..	Old Cranleighans
,, 16	H.O.P.	(2.30) ..	Esher
,, 30	Croxley Green	(2.30) ..	Old Merchant Taylors

BLUES

The following blues were awarded for the 1966 Summer Season. (Our apologies for the delay in printing, but once again the following have only just been received.)

CRICKET CLUB

J. Butchey ... ... Full Blue
M. Appelby ... ... Full Blue
R. J. Beacham ... Half Blue
J. Griffiths ... ... Half Blue
R. Clark ... ... Half Blue

RIFLE CLUB

No applications for Full Blue.
N. Hopkinson ... Half Blue

LAWN TENNIS

J. H. Newman ... Half Blue
No applications for Half Blue.

ATHLETIC CLUB and CROSS-COUNTRY

D. J. Osborne	...	Full Blue
D. Barford	...	Full Blue
D. Choate	...	Half Blue
P. Bundred	...	Half Blue
A. Ross	...	Half Blue

No applications forwarded by the Cross-Country Club.

FENCING CLUB

L. Cree ... ... Full Blue

No Half Blues awarded.

SAILING CLUB

No applications for awards.

LADIES' CLUB

No applications for awards.

SWIMMING CLUB and WATER POLO

No applications for Full Blue.

D. Foulds	...	Half Blue
A. R. Froom	...	Half Blue
S. J. Challacombe	...	Half Blue
P. Ashford	...	Half Blue
Miss J. Abels	...	Half Blue

RUGBY

GUY'S v. BROMLEY

At H.O.P. Sept. 9th, 1967

Result: Won 38-0

In this, the pot warmer to our 124th season, Guy's again proved too strong for Bromley who turned out a much better side than in the previous encounter. The Guy's side lacked two old faces in J. E. Davis and A. J. Kindom who have qualified and departed but welcomed back a third old face in P. K. Peace, who has returned to the Anatomy department, and fills a rather larger space than previously in the second row.

Rowlands kicked off for Guy's, with a slight breeze at their backs, and the Bromley line was soon under pressure. It took Guy's twenty minutes however, to crack the spirited Bromley defence, when Cheesborough executed a dummy scissors with Price, found a gap and scored, Elliot converted.

Guy's looking far the better side, and entertainingly throwing the ball about, were hampered by a very strict referee, and typical early season mistakes, especially by the backrow. The pack gradually got well on top with Thorburn and Curzon showing the way in the loose, and Hey taking a dozen plus against the head, and being very frisky, to little avail, on the opposition line. Before half-time Guy's scored through a penalty by Elliot and a good try by Beacham beatifully (!!) put away by Rowlands on the blind side. This left Guy's 11-0 in the lead at half-time with a heavy pack and the wind to face in the secoind half.

The second half began with a great Bromley revival and the Guy's line was pounded for about ten minutes but these attacks were driven back by a good Guy's defence, and good forward rushes saw Guy's once again on the attack, whereupon the Bromley defence cracked.

The pack asserted its authority and the points mounted as Bromley were pinned to their line due to the forwards' ability to dominate the secondary possesion. With good loose ball the backs ran well for tries to come from Rowlands (3), Cheesborough, Beacham and Thorburn, Elliot converting three of these and kicking another good penalty.

The main feature of the game was the way Bromley were forced back, when in possession by the forwards who gave Swift ball at varying quality, Swift in turn, at times under great pressure did well to give Rowlands a good service. Rowlands used this to good effect in either setting up his threequarter, or himself!

Team: D. R. Elliott, R. J. Beacham, J. E. Price, M. Cheesborough, D. Lewis, B. J. Rowlands, P. G. F. Swift, H. Burry, G. B. Hey, E. Neville, J. M. Cockburn, P. K. Peace, D. A. Curson, C. G. Neville, C. W. Thorburn (Capt.).

WATER POLO

GUY'S v. SHELL LENSBURY

Result won, Shell Lensbury, 5; Guy's 7

The match got off to a late start in the magnificent shell building pool, but a fine even contest ensured, the result being in doubt until the final goal. Soon after the start, with Guy's attacking the shallow end, Foulds appeared up with the forwards and scored with a good shot from ten yards out. However, Shell, relying on two good players soon equalised. At this stage Forbes was belying his fitness and commanding the centre of the pool, and from his pass Challacombe put Guy's ahead. An attack of cramp (or was it just a bad defensive lapse) let Shell in for the equaliser at the beginning of the 2nd quarter, but straight from the restart Challacombe found himself unmarked and scored Guy's third goal, only for Shell to level the scores by half time.

In the third quarter Howard and Challacombe put Guy's two ahead, but with some midfield tiring slightly Shell scored twice more to equalise again, in spite of the brave efforts of Wood in goal. In the final quarter, Guy's at last got the better of the Lensbury Club and two shots by Challacombe decided the issue. One brought a goal, and the other a rather wild shot, crashed off the bar to Ashford who nipped in smartly to score the final goal.

Scores: Howard, Ashford, Foulds, Challacombe (4).

Team: S. Challacombe, D. Foulds, A. Forbes, K. Howard J. Wood, A. Aspin, P. Ashford.

HOSPITAL INFORMATION

APPOINTMENTS VACANT

GUY'S HOSPITAL DENTAL SCHOOL

Applications are invited for the appointment of **Lecturer** (half-time) in the Department of Conservative Dental Surgery with duties commencing as soon as posible. Salary in the scale £1,745 x £135 to £2,150 x 125 to £2,650 x £115 to £2,765 x £55 to £2,820, with superannuation.

Forms of application are obtainable from, and should be lodged with, the Dean, Guy's Hospital Dental School, London, S.E.1., not later than **Saturday, 30th September 1967.**

GUY'S HOSPITAL, S.E.1.

Applications are invited for the post of **Registrar in Clinical Pathology,** with duties to commence as soon as possible and appointment

until 30th September 1968. Forms of application are obtainable from the Superintendent, Guy's Hospital and should be returned not later than **25th September 1967.**

GUY'S HOSPITAL S.E.1.

A 10 month course for female **Dental Hygienists** will commence in April 1968. Candidates must be at least 17 years of age and should have obtained a minimum of four G.C.E. subjects at 'O' Level. Application forms, obtained from the Department of Preventive Dentistry, Guy's Hospital, S.E.1 should be submitted by 6th October, 1967.

BUCKLAND HOSPITAL, DOVER

House Surgeon (othopaedics)—at Buckland Hospital, Dover. A new appointment, with Guy's Consultant. Preferably pre-registration. Advertised in **BMJ** 2nd September. Details from Mr. Gordlife, Appointments Bureau, Guy's Hospital.

PASS LISTS

ENGLAND
ROYAL COLLEGE OF SURGEONS OF

Final L.D.S.

J. W. Barnard*	D. A. Graham*
Elaine D. Black*	Penelope J. Heather*
R. A. Burroughes*	M. J. H. Jones*
B. C. Church*	C. H. W. Lee*
Elizabeth A. Cocks*	M. C. R. McMahon*
J. K. Crafts*	Frances M. Pratt*
R. A. Cramp*	R. A. Stares*
S. W. Finch*	Diana J. Wagstaff*
A. A. Forbes*	R. M. Watson*

*Have completed the examination

Handcock Prize

P. J. Leopard

SOCIETY OF APOTHECARIES OF LONDON

D.I.H.

D. B. Sudgen

UNIVERSITY OF LONDON

Ph.D.

Valerie A. Cowie
T. K. Das Gupta

M.Phil.

Vera C. Marsden

2nd. B.D.S.

P. N. Adams	P. J. McDonald
B. M. W. Bailey	J. C. Miller
R. D. Barough	P. J. M. Moulder
J. C. Beckerson	G. P. Northcott
D. K. Briggs	J. N. Palfreyman
E. P. Brown	B. A. Parker
M. J. Carter	Susan Parry
Margaret E. Cartwright	D. P. Pascoe
F. D. K. Chan	K. Pittel
C. J. Clare	Diane Plamping
J. A. Cope	D. Powell
J. S. Cowling	Mary D. Powell-Cullingford
D. R. Crafts	Sheila M. Radcliffe
R. C. Crofts	Emily E. Richards
J. L. Curtis	P. S. Richardson.
J. P. Dine	P. D. Robinson
P. A. Epps	S. F. Roper
A. M. Evans	D. Searle
P. J. Evans	P. Sharples
C. R. Farrant	E. J. Shillitoe
Felicity J. Francis	J. Stock
Jane R. Goodman	Ann V. Tapsell
H. Greenway	Joane C. Timmis
W. F. Haines	J. W. Toplis
N. W. T. Harradine	A. J. Walter
Hilary C. Hodge	S. H. Ward
P. G. Jenkins	G. R. Waterhouse
R. J. Lane	Pamela J. M. Watson
Mary Law	M. G. Watt
I. H. Learner	G. N. Wolffe
R. V. Leeburn	Christine E. J. Woods
B. P. Levy	B. A. Wooster
I. J. McClure	B. A. Wright
D. J. McConnell	

PERSONAL

DENTAL ASSISTANT with view to partnership required by three Guy's men in East Anglia. Box No. 8/2

THE HARLEY STREET NURSING HOME
LONDON W.1.

Resident Senior House Surgeon required. 60 bed unit, mostly acute and major surgery. Only recognised Consultants in attendance. Would suit Doctor studying for higher qualifications. salary £1,000 p.a. plus considerable Assistant's fees Apply Medical Director.

CHANGES OF ADDRESS

R. C. Carrington Esq. M.A., D.Phil. St. Olave's Goddington Lane, Orpington, Kent.

Christopher Clegg B.D.S., (London) 76, Castle Street, Farnham, Surrey.

Dr. and Mrs. I. T. Field, 10, Rockells Gardens, Dulwich Wood Park, London, S.E. 19.

Leslie J. Godden F.D.S., Flat 4, 2, Berkeley Place, Tunbridge Wells, Kent. Tel. 26044

John V. Jeffs F.R.C.S. to Woodpeckers, Heathridge Green, Cobham. Surrey.Tel. Oxshot 3177

Also 148, Harley Street, London, W.1. Tel. Welbeck 1207

Dr. J. Gaymer Jones, 1, Girton House, Manor Fields, Putney Hill, London, S.W.15.

Dr. and Mrs. D. S. Robertson, 55, Slayleigh Lane, Sheffield, 10, Yorks. Tel. Sheffield 32219

J. Collen Schofield B.D.S., D.D.S. Suite 511, Mills Square Tower, 100 South Ellsworth, San Mateo, California 94401 Tel. 415-343-1083

Home address: 935 Culebra Road, Hillsborough, California 94010 Tel. 415-347-3202

Major General P. R. Wheatley, Sherwood, High Park Avenue, East Horsley, Surrey. Tel. *East Horsley 2151*

BIRTH

MAY—On 18th July at Farnborough Hospital Kent, to Diana and Roger May a son, Jonathon Roger—brother for Timothy, Stepharnie, Robert and Phillippa

We would like to remind our readers that all copy for inclusion in the Gazette mut be received eight days before the publication date.

Personal notices one shilling per word (Minimum £1. 1s 0d.)
Birth, Marriage, Death and Change of Address notices are without charge to subscribers.
Non-subscribers will pay £1. 1s. 0d. for all notices other than Personal.

GUY'S HOSPITAL GAZETTE

EDITORS D. S. ROBINS and C. B. BROWN
SPORTS CORRESPONDENT J. G. PAYNE
NURSING CORRESPONDENT E. A. MALPAS

FORTNIGHTLY TWO SHILLINGS VOLUME 81 NUMBER 2066

The opinions expressed in these columns are solely those of their authors and are not to be taken as the views of the Hospital as a whole.

PASSIM

An Individual Decision

For as long as medicine has existed doctors have lived close to death. In serious illness the doctor might be considered the bookmaker, one of whose consistent and optimistic clients is Death. In every situation he offers odds against this punter's winning, odds however which have in their estimation an assessment not only of the type of situation but also of the many environmental influences prevalent at the time. Every time the bet is laid fresh odds have to be arranged.

The Press have done a dubious service to the community regarding yet another aspect of medical life. They have brought the delicate and intensely personal question of resuscitation of the apparently dead patient into the debating forum of all but the confirmed world-weary, in such a way as to make the subject almost obscene.

The ease of certification of death is indirectly proportional to the time lapsed since the apparent departure of life. The moment of death is as yet not satisfactorily definable*. What is often easier to determine is the likelihood of death being a natural consequence of the particular antecedent factors, the disease and the patient's powers of resistance. Such an assessment depends as much therefore on known statistical precedents as on the individual patient and his individual medical attendant.

By creating a public issue of the recent hospital notice on the subject the uniqueness and, if we may use the word, individualism of a particular case is threatened. As it was threatened by the nature of the notice in question, so is it threatened by the creation of a public feeling of horror at the thought of a doctor deciding not to employ measures which *might* restore life to a body from which it has appar-

*A future article in our series of Current Medico-Legal Problems will deal with this specific point.

ently departed. It may also be threatened by any edict of an opposite nature on the subject from even more elevated medical powers.

It is a fact that in hospitals every day decisions are taken by medical staff on whether a patient will be the recipient of measures to bring him back to life from an apparent death. These decisions are, of necessity, made in advance in cases where death is a likely sequel in the near future. For resuscitation to be of any value, and it should not be forgotten that only a small number of resuscitative attempts are truly successful, it needs a fully-qualified medical decision on the spot at the time to be made. This criterion is rarely fulfilled, so that the nursing staff who are on the spot at the time must know what action is required of them. There is little more distressing to all concerned than the attempt at resuscitation of the patient whose death is expected in the immediate future, unless it is the successful resuscitation of one whose higher mental functions have ceased to exist.

The decision of resuscitation is one which is intensely individual, which has to be made with a clear mind and conscience and which is in no way aided by either edicts from superior medical powers, be they consultant or ministerial, or by news vultures whipping up public emotion. It is a decision which is never taken lightly and which is probably the hardest any doctor has to face. But face it he must. All the factors have to be weighed, and not the least important of these is whether the maintenance of a living body is a preservation of life. Fighting against death and disease is the stuff of medicine, but prolonging the act of dying is not.

Trial by Exam

Visitors to the Wills Library at this time of the year may well raise a quizzical eyebrow at the numerous bowed heads before open and well-paged textbooks. Is it not still the summer recess? Yes, but not for those brow-beaten clinical students. Conjoint and M.B. are upon them, dear lads.

Fingers more accustomed to the smooth surface and sharp edge of the playing card unfamiliarly hold a pen.

Palms which hovered over the well varnished edge of the billiard table are now only fit to help balance the weary head upon its bony staff.

Eyes that of late enjoyed the shapely leg and well-turned heel now solemnly scan the mournful black type of HJT.

For some it is too much, the head lolls back slowly, the eyelids flutter and close. But the craftsman of the Wills Library chairs knew well these possible diversions from work and so the head meets solid wood on its way down, and sleep is prevented.

For those who reach the end of their tether in the fight against that chair there is the North Common Room; quiet, warm, comfortable—in short offering all the soporific requirements for the man who wants to get away from it all.

But the ambitious, the studious, the fearful toil late. At nine, they wearily pack their books and trudge despondently home.

The next morning a colleague pounces from behind—"Thirty causes of flat-feet, bam, bam, bam; twenty causes of death; what is Pseudo-Xanthoma Elastica?" "Do I know enough; Oh lord, I didn't know that, did you, Bob? Well it's not in HJT." With that comment, all who didn't know give a sigh of relief. (They say you can pass Conjoint Med. and Path. just on HJT!)

Two to three days before the Day of Judgment, anxiety diarrhoea may have become a prominent clinical presentation, bitten nails and increased cigarette consumption sometimes being as important. On examination, the pulse is rapid and full, the extremities alternating from hot and sweaty to cold and clammy. Hearing is often impaired and memory somewhat confused. The picture rarely presents as a state of collapse and the second person to call for (the first being the registrar—No. 1 on the list of management for all emergencies) is that Man from the Television!

But as rapidly as it apparently came, so it passes. The successful candidates rejoice and those who have not satisfied the examiners steal away to their respective holes to mourn in sackcloth and ashes.

GUY'S DIARY

OCTOBER

3rd	Tu	1.00	Clinical Lecture. Dr. MANN. "Gout."
5th	Th	1.00	Clinical Lecture. Mr. WASS. "Diverticulitis of the Colon."
10th	Tu	1.00	Clinical Lecture. Mr. BEARD.
12th	F	1.00	Clinical Lecture. Dr. SCOTT.
15th	Sun.	7.30 p.m. in the Chapel. A Service to mark St. Luke's Day, for all members of the Hospital Community. The Service will be led by the Resident Chaplain. Address by H. Fletcher Lunn, F.R.C.S. Music by Musica Medica.	

PROFESSOR W. E. HERBERT

— *An Appreciation*

The retirement of Walter Herbert from the Chair of Dental Surgery marks the fulfilment of nearly half a century of continuous and conspicuous service to Guy's Hospital and its Schools, for it was in 1920 that he was admitted as a student. By 1928 he had obtained qualifications both in dentistry and medicine, and in the following year he was awarded the travelling scholarship which took him to the Northwestern University Dental School of Chicago. On his return he was appointed a part-time demonstrator in operative dental surgery and also entered a leading private practice. At that time it was quite unusual to have whole-time teachers in dental schools, but so much was Herbert's teaching seen to benefit the School that it was soon decided to give him a full-time appointment, and in 1933 he was appointed by the University of London to a Readership which he combined with the post of Director of the Department of Conservative Dental Surgery. Those who can remember such already distant days will recall how great an improvement was effected by the introduction of a carefully planned and uniform course of teaching, which was the admirable supplement to the sometimes inspired but often very individual variations of teaching offered by honorary staff each attending on his own particular day.

It was only five years later that Herbert was appointed to the first whole-time Chair in Dental Surgery to be held in the University of London, and he came to be very closely associated in fact with the development of dental surgery as an academic subject both in his own and indirectly in other universities. At that time Professor Evelyn Sprawson was the quasi-permanent chairman of the Board of Studies in Dental Surgery and Herbert became the quasi-permanent secretary. When he finally succeeded to the chairmanship in 1951 one of his first actions was to propose a limit to the term of office such as has since then prevailed.

There is no doubt that his long and close experience of both the Board of Studies and the Board of Faculty of Medicine and his twenty years of service as hon. secretary of the Dental Education Advisory Council, and at times secretary and chairman of the Association of Dental Hospitals were of very great assistance to the development of dental education and hospital practice both at his own and at other universities.

Although his own department was concerned with conservative dentistry, Herbert, by virtue of his appointment as Dental Surgeon to Guy's Hospital, always exercised his right to engage in oral diagnosis

and surgery over a wide field. This no doubt helped to make him one of the best examiners, whose services were continually sought by universities and Royal Colleges.

On the House Committee and other Hospital committees his experience and commonsense were much valued, and his appointments to the Board of Governors of the Eastman Dental Hospital and to the Committee of Management of the Institute of Dental Surgery were appreciated by both.

Whether the result of natural aptitude or diligent study, Herbert has a remarkable ability for remembering the names and characteristics of hundreds, perhaps thousands, of students who passed through his hands. There must be a similar number who equally recall his remarkable patience occasionally illuminated by a shrewd thrust, his complete refusal to be hurried in any way or to alter his opinion without sufficient cause, and who owe to him both the development of their skill and their confirmation in the attributes of professional integrity which mean so much in dentistry. Probably few members of the dental staff received as often as he the compliment of being asked to give professional advice and help to his own colleagues in the Hospital, and none exceeded the patient sympathy and skill which he offered.

At various intervals in his career Herbert revisited the U.S.A. and other countries, particularly Scandinavia where he had many friends. One of his earlier visits was in fact at the instigation of Sir Arthur Hurst, and had to do with a controversy about the relative importance of short drinks and oral sepsis in the pathogenesis of carcinoma of the stomach. Which won is not now recalled, but the article in *Guy's Hospital Reports* was the forerunner of some forty publications dealing with all aspects of his speciality. It was perhaps on this same voyage that after lecturing in Stockholm he had the unusual experience of being congratulated by an Argentinian post-graduate on the excellence of his English. Like his brothers, one of whom was president of the Alpine Club, Herbert has been an enthusiastic rock-climber, and the sharing of this mystique has been a close bond between him and many students and colleagues. A keen but not too skilful skier in Norway and Switzerland, he was frequently optimistic enough to appear on Box Hill on a wintry week-end.

His name was one of the early elections to the F.D.S.R.C.S., and among other evidence of the esteem of the profession was his election as President of the Odontological Section of the R.S.M. in 1961. The regard of the students was expressed in their electing him President of the Dental Society no less than three times, in 1937, 1952, and 1964, a thing which has happened to nobody else.

He has left a splendid record of service which will long be remembered at Guy's and wherever Guy's graduates are found. These will join in wishing him and Joyce, his wife, all the pleasures of retirement they have earned and the enjoyment of the society of their children and grandchildren for many, many years.

M.A.R.

OUTSIDE THE IVORY TOWER

Undergraduate Education in the Setting of General Practice

by

J. A. D. ANDERSON

Introduction

Until about two centuries ago instruction of potential doctors was based on dogma handed down from generation to generation. Galen in 200 A.D., taught that disease was caused by variation in the four humours and this theory was accepted almost unchallenged for well over 1,000 years. The tradition was so well established that any exponent of a new theory met with bitter opposition from contemporary medical opinion. Anyone holding contrary views was considered at best to be disloyal to his medical school and at worst to be guilty of sorcery.

The second phase of medical education was that of scientific observation and achievement. This phase began in earnest during the course of the nineteenth century, though the science of anatomy, for instance, is probably as old as the art of medicine. Scientific observation and teaching has been advocated by such pioneers as Harvey, Jenner and Pasteur throughout the ages but as the nineteenth century moved into the twentieth, science became the dominant feature. Concurrently the focal point of treatment moved from the patient's home to the hospital with its greater facilities for scientific investigation. The broad fields of medicine and surgery became more and more sub-divided and clinicians accepted instruction from scientists without medical qualifications. The medical student of this second era was moulded so that the finished product became a scientist with a knowledge of human illnesses as expressed in terms of pathological syndromes.

The third era of medical education did not reach its full stride till after the Second World War, and is still only half developed. Both patients and doctors have come to learn the fuller significance of the psychological and social aspects of illness. Patients enjoy the fairy-land tales of 'Emergency—Ward 10' and 'Dr. Kildare', they are afraid of hospitals and specialists with their white coats and magic, but in spite of this many yearn for home care and family treatment.

These three phases in the history of medical education have been given clear cut boundaries but elements of all three backgrounds are to be found in the modern product of our medical schools. The newly-qualified doctor must have authority and dogma for the first era, he must have the scientific knowledge and enquiring mind of the second era and he must have a grasp of the social and psychological factors affecting a patient, which springs from the third era.

In the past the doctor was regarded solely as a healer of sick people. Training potential doctors was based on a system of apprenticeship, and since sick people were collected in large numbers within the walls of a hospital, it followed that medical students served their periods of apprenticeship in those institutions. This apprenticeship is perpetuated today in the teaching rounds which famous consultants hold when they are not attending conferences in sub-tropical resorts or scraping livelihoods out of Harley Street. When the scientists became involved, they too moved in the hospital arena and their proliferation has meant that more and more of them have been squashed into the limited space available. No recess or cupboard within the hospital, no shop or other space near its gates can remain empty for more than a few weeks without being in danger of annexation by white coated workers who count or measure some part of a sick person.

Enthusiasts from each new speciality of science clamour for time on the undergraduate curriculum. Once this has been achieved, those concerned resist any attempt to reduce the allocation, since "teaching time" is regarded by some as a status symbol matching in importance the "number of beds" controlled by the clinician. It is against this background that suggestions are being made that the medical course, already bulging at the seams, should include a period of time spent in the study of general practice.

It can be argued that general practice is a postgraduate subject and few would dispute the need for a period of postgraduate vocational training for those intending to enter this branch of medicine. The same can be said also about Obstetrics, Paediatrics, Psychiatry or Surgery, to mention but a few of the subjects which are currently taught as clinical subjects. The important issues are: should all medical students be exposed to clinical situations outside the walls of the hospital? And should this experience be brought about regardless of the field of medical practice that is to be followed after graduation?

One of the features of the British system of financing universities is that each Medical School is free to decide on its own course of action. The fact that this free choice is largely governed by the opinions of those who are themselves hospital specialists should perhaps give food for thought but it is unlikely that this state of affairs will change in the foreseeable future. It follows, therefore, that no scheme, however attractive or exciting it may appear to enthusiastic members of the staff or to students, is likely to get further that the decanal waste-paper basket unless it is supported by evidence that this extra teaching will fulfil an unmet need. In addition, the scheme which is proposed must be workable and the time allocated for it in the calendar must match up to the need for the extra tuition. The purpose of this paper is to put forward some arguments in favour of instruction from outside the hospital and to indicate which aspects of medical care lend themselves to being taught in this way. It includes a description of some of the ways in which some students already benefit from this form of teaching. Even if these arguments and views were accepted there would remain the interesting but delicate task of convincing one or more members of the professoriat that the new subject should be taught during time which had hitherto been allocated to them.

General Practitioners differ in their habits of referring patients to hospital. Studies have been made in this field: by Brotherston and Chave[1] suggesting that 18.3 per cent of registered patients are referred to hospital during the course of a year. Fry[2] reckoned that 7.8 per cent of his patients were referred for out-patient consultations and a further 0.7 per cent for admission. One reason for the difference is that Fry had open access to certain pathological and radiological examinations without reference to a Consultant Physician. An unpublished study by Scott[3], also having open access to diagnostic facilities, indicates that between 2—3 per cent of consultations in general practice result in the patients being referred to a consultant for some reason or another.

Whichever of these figures is considered, it follows that medical students whose clinical instruction is confined to patients who attend hospital may at best be getting a biased picture of the morbidity pattern of the population or may at worst be lacking in clinical knowledge of certain common diseases.

There is a second shortcoming in the education of those who qualify without setting foot outside the hospital, and that is the limited period for which a sick patient comes under scrutiny by the hospital staff. Most of us have heard distinguished specialists criticising general practitioner colleagues for delaying too long before referring a patient or for errors of diagnosis. Many students to whom these criticisms are addressed will have no chance of seeing the circumstances from which referrals to hospitals are or are not made before they themselves either have to occupy the consulting room

chair in a general practice or take their turn as specialists criticising their colleagues. Methods of long-term care for those who have been discharged from hospital but who still have residual disabilities can only be known theoretically by those who have not had a chance of seeing them put into operation. Practical knowledge of this kind is another aspect of medical care which is shown in only a limited way to those who are trained entirely in hospitals.

Aims

The aims of any instruction should be to impart factual knowledge and to produce an attitude of mind which will enable the student to assimilate further knowledge in the subject itself and integrate relevant knowledge in allied subjects. Both factual knowledge and attitude of mind may be influenced by reading or by theoretical instruction, but the basis of medical education today is that both will be lastingly affected by practical demonstration.

The incidence of carcinoma of the rectum may be described in the classroom; the surgeon may even remember to mention it at the bedside when he is describing a case. Until he has seen for himself, however, the student has little idea how many patients with colds, headaches and other complaints have to be seen by the practitioner, nor how many patients with bleeding haemorrhoids have to be examined before one (perhaps the only one in a lifetime of general practice) turns out to be a rectal carcinoma.

The manifestations of disease from earliest symptoms through to terminal stages can be described in books or at the bedside; this is no substitute for personal confrontation. Why is it that one screaming child with a temperature of 100° F. has recovered completely by the next morning while another is desperately ill and may require hospital care to prevent serious illness or even death? Similarly the help which may be given to those with chronic illnesses and handicaps who are living at home can only be demonstrated effectively in the home. The statutory and voluntary services available in the community can be listed in works of reference but their place in the supportive care of sick people can only be fully understood when they are seen in a real life situation. This knowledge is important not only to future general practitioners but to future specialists who will have to decide whether patients need to stay in hospital or if they can be allowed to return to the comfort of their own homes.

Some gaps in medical training which might be met by a period outside the hospital are summarised here. They include both factual and attitudinal aspects.

1. Recognition of diseases in their earliest stages and their identification from the mass of unselected clinical material confronting the general practitioner.

2. Efficient triage into those who require specialist advice or treatment, those who can be treated effectively by medication, and those who will respond to encouragement and advice.

3. Acquiring first-hand knowledge of diseases which are seldom referred to hospital.

4. Continuity of patient (and family) care beyond the period of intensive hospital treatment. This includes instruction in the long-term management of chronically ill, disabled or geriatric patients who have been discharged from hospital.

5. The relationship of one person's illness on the family and vice versa.

6. Practical demonstration of the many ways in which medical services can work together and with other community services to help patients; also appreciation of the limitations which apply to liaison of this kind.

7. Appreciation of the relative importance of different diseases in the community as a whole both in terms of numbers affected and disability caused; this includes public health, immunisation and screening for disease.

8. The problems arising from freedom of access by patients to their medical adviser both in the early and late stages of disease.

Methods

There are several different approaches to the problem of how best to expose students to medical care outside hospital. Most medical schools would claim that their students are encouraged to broaden their knowledge and the methods described here are not intended to include all the different approaches which are being made. They give an idea of the degree of involvement which can be achieved in different circumstances.

(1) Case conferences about patients currently in hospital; this is done at Guy's in relation to paediatric patients. St. Thomas' Hospital makes this approach by means of obstetric patients, while elsewhere use is made of patients from other wards. This system has the advantage that it can be done in time allocated to the particular speciality and that it is a fairly simple method of exposing students to a few of the problems of after-care in the home and to the use and deployment of community health, and welfare services. Each student may be involved deeply in the problems of one family; even so there is little opportunity for follow up to find out what happens after the

patient leaves hospital, or to ascertain the extent to which theoretical concepts become practical realities.

(2) Attachment to general practitioners; at several medical schools a list of *suitable* general practitioners is kept, and students can apply to go to one of these for a period of attachment. At many schools, including Guy's, these attachments are voluntary. It follows that only those who are interested are likely to attend; the remainder, taking their lead from the top, may regard general practice as a waste of time and therefore choose to have all their undergraduate experience within the confines of hospitals.

Even when attachments are obligatory, the criteria of *suitability* are seldom laid down nor is it clear to either the practitioner, or to the student, what is to be demonstrated or taught during the period of attachment. Elsewhere the result is that the student will be shown the running of the practice but that no attempt must be made to teach clinical medicine. This injunction would perhaps be less lamentable if one could guarantee that all those who were empowered to give the clinical instruction (presumably the staff of the hospital) were competent teachers.

(3) Full-time attachment to a special unit; this is the method used at Manchester. Ideally the staff of such a unit hold appointments in the Medical School and the nature and scope of their teaching is integrated into the plans for the whole curriculum. The period of attachment is unlikely to be more than two weeks and therefore there is little chance of seeing long-term continuity or the practical results of planning care by the use of the community services. On the other hand, the student is totally involved during the short period of attachment and cannot opt out in order to do some "important" work in the wards or laboratories of the hospital.

(4) Part-time attachment to a special unit; this is currently operating at Edinburgh. Students attend for two or more sessions a week, for a period of 10-12 weeks. One of these sessions consists of attendance at the consulting room of a general practitioner who has an appointment on the staff of the medical school, followed by visits to patients' homes with that practitioner. The second session consists of a discussion or seminar. The early ones deal with the role of the family doctor in general, while the later ones deal with the management of patients and families whose care is being organised by one of the students under the supervision of the doctors.

The fact that the attachment goes on for so long gives some idea of continuity of care and of the changes which may occur in long-term illness. On the other hand the part-time nature of the attachment enables the disinterested students to opt out more easily.

(5) Long-term allocation of families; this is favoured by some medical schools in the United States. Students are allocated to one or more families at the start of their clinical work and they continue

to care for these people during the remainder of the course. This can include the provision of all domiciliary medical needs and clerking duties in the hospital if any member of the family is admitted. This system exposes the student to the problems of long-term care and where the staff of the medical school give active support, it is quite successful. This method might be difficult to implement in Britain, however, since every family is entitled to the care of a qualified general practitioner. Furthermore, it is unlikely the curricula for medical schools could be altered to the extent which would be needed to administer such a system.

Problems in London

One of the problems facing many of the London Medical Schools is to define their populations. Patients come from far afield, and there is considerable overlap between the catchment area of the teaching hospital and another. Furthermore, the areas of heavy population which formerly surrounded many of these hospitals are now being altered through development and rebuilding so that the density is considerably reduced. It follows, therefore, that general practitioners working nearby are unlikely to welcome the establishment of special teaching practices for instructional purposes. If such practices are necessary, then they must be found in outlying areas such as the new community of Thamesmead, being established on the marshland near Erith, where houses for 60,000 or so are to be built.

There are two disadvantages to using such an area for this type of teaching. The first is that the medical care being planned for the area is extremely complex and atypical as far as the general pattern of the country is concerned. Full laboratory and X-ray facilities, comprehensive screening programmes and computerised records may well form the pattern for community care in the future; as such, it may be useful to let the doctors of tomorrow see what can be achieved. The establishment of a general practice teaching unit based exclusively on such a health centre, however, would be like confining the teaching of medicine inside the hospital to the intensive care units.

The second drawback about using an area like Thamesmead is that the distance from the hospital (10 miles) means that Guy's is not the district hospital for the area (nor are the associated hospitals, New Cross or St. Olaves), so that patients seen by students at Thamesmead will probably get their hospital treatment at the Brook or St. Alfeges. This will make it more difficult to put across the idea that illness is a continuous process and that patients do not change whether they are in hospital or out of it. The distance will also serve to emphasize in the student's mind the idea that general practice is different and separated from hospital practice.

An alternative method of letting students gain experience of community care is to use the population round the hospital and to

invite co-operation from some of the local general practitioners and the Medical Officer of Health. Joint appointments for the study of health and sickness in the community have been made by both University College Hospital and the Royal Free Hospital in co-operation with the Borough of Camden. At St. Thomas' Hospital, a special tutor has been appointed whose aim is to co-operate with local practitioners in order to introduce students to medical care in general practice.

The way in which these and other ventures develop must await the passage of time but the following is a suggested programme. It is built up partly from experience in the Department of General Practice at Edinburgh, and partly from studying the programmes of other medical schools.

Suggested Syllabus

Instruction would be spread over a period of eight weeks. Each week a student would spend one session alone with a practitioner in his consulting room, one session in group discussion and a variable time in addition arranging the care of patients allocated to him by his tutor.

Every week, each student would attend the surgery of a local general practitioner who would be his tutor. Together they would see the patients attending the consulting room followed by a few visits to families. The patients seen both at the consulting room and in the homes would be those with routine appointments and such emergencies as were dealt with during the normal course of events. The numbers of patients seen during the consulting hour would have to be limited as the presence of a student and the need for discussion would reduce the speed of working.

In addition to these unselected patients, general practitioners would be asked to make sure that each student was introduced to special patients designed to illustrate particular problems. These would be agreed upon between the practitioner and the medical school and would vary depending on the current pattern of medical care and teaching policy. Suggestions for the present time might include handicapped child; patient with chronic disability; temporary indisposition of mother because of confinement or sickness; problem families; effects of long-term illness of one parent; child health session; mobilisation of health and welfare services in a crisis.

A student would be allocated to one patient or family; he would visit subsequently on his own and arrange such care as was necessary subject to the supervisory approval of his tutor. The amount of time spent on this aspect of training would vary from student to student in much the same way as the amount of time spent on clerking of ward patients varies with the type of patients and with the interest

and enthusiasm of the students concerned. Since the patients would be near the hospital, it would be possible for students to supervise home care without interfering with other commitments.

At the second session in each of the eight weeks, six students would meet together with their tutors for a seminar, at which full-time members of the medical staff would be present. At the first four of these seminars, the points listed under "Aims" would be discussed. At each of the next three sessions, two students would make a case presentation about a patient under his "care", while the final session would be reserved for general discussion and feed-back.

If participating doctors had two students attending at different consulting hours for three periods of eight weeks in any year, then eighteen practitioners could cope with an annual throughput of 108 students between them. Under such arrangements, three separate seminars would be held each week.

Conclusions

Most doctors, including those with highly specialised interests, subscribe to the idea that sickness and health cannot be equated merely with the presence or absence of pathological lesions. Every disease has physical, mental, emotional and social components and the effect of each of these on the whole picture must be borne in mind when considering aetiology, diagnosis and prognosis and management. Many of those who acknowledge that these ideas should form an integral part of medical education remain convinced that they can be put over more efficiently by those who are responsible for the care of patients in hospitals. Those of us who recommend that medical education be extended to include teaching in the setting of general practice claim that the above concepts, together with basic information about the epidemiology of diseases (especially the chronic ones), and the services available to cope with sick people at home can best be taught by a period of practical instruction outside hospital.

This paper seeks to describe the particular aspects of medicine which might be demonstrated practically through attachments to general practitioners. Some of the ways in which this type of teaching is being carried out in different medical schools at the present time are presented and one method by which this could be achieved at Guy's has been put forward in the hope of stimulating discussion and perhaps even action.

REFERENCES

1 Brotherston, J. H. F., Chave, S. P. W. (1956). Brit. J. Soc. Med., **10**, 200.
2 Fry, J. (1957). Brit. Med. J., **2**, 1453.
3 Scott, R. (1960). Personal Communication.

CURRENT MEDICO-LEGAL PROBLEMS

2. THE BATTERED BABY

Newborn infants have been subjected to the closest scrutiny for centuries—both by those who wanted them and by others who did not; by the obstetrician, jealous for his statistics, the paediatrician concerned for the child's welfare, and by the pathologist and police. All have a keen interest in the health and survival of the infant, in stillbirth, difficult delivery, the problems of immaturity, neonatal disease and in the field of trauma. And now, in the last twenty years, we are faced with a new problem—the vicious, ill-tempered, brutal handling, bashing and sometimes killing of infants, usually by their parents and in the first year or two of life—"baby battering". This new kind of baby-killing has emerged more fully in the last ten years following a near-recognition of it by Caffey, the American radiologist, who, in 1944-5, noticed increasing numbers of children in the two to six year range coming to his clinic with fractured arms and legs, ribs and skulls, "pulled" epiphyses and the like. He suspected them to be suffering from some kind of fragility of bone. Independent reports from Silverman in 1953, Woolley and Evans in 1955 and finally Kaupe in 1962, by now some fifteen years later, finally nailed the condition of "Caffey's Syndrome" as frank trauma. These children were being secretly battered by their parents or guardians who gave misleading explanations about them when, tardily, they were forced to bring them for treatment for fear they might die: nurses and doctors were being deliberately mislead.

TYPES OF INFANT KILLING

Neonatal and infant deaths that are *not* natural fall into the following classes—in law:—

1. *Stillbirths* under suspicious circumstances, and *Concealment of Birth.*
2. *Want of Attention* at birth.
3. Deaths from deliberate—wilful—acts or omissions within twelve months by the mother—*Infanticide.*
4. *Wilful Neglect* of children.

5. *Ill-treatment or Causing Unnecessary Suffering.*
6. *Murder*—deliberate killing outside the special terms of infanticide. (The distinction between murder and criminally careless killing—manslaughter—is unlikely to be made unless death results from neglect or suffering that has not been attended to.) The dead battered baby is, as a rule, treated as murder—and in my view rightly.

RECOGNISING THE BATTERED BABY

Doctors, nurses, infant welfare workers, health visitors, social psychologists and psychiatrists, paediatricians—and, in the police world, probation officers and W.P.C.'s—the women in the force, must all be on the "qui vive" for the child "at risk" of battering as well as for the injured or dead. The wretched infant cannot speak for itself at the peak age of incidence—around two or three or four years: it is hurt and cowed, often frightened, and it needs an aware understanding of its plight by those around it. How is it to be recognised There are six classical features:—

1. The *infant, usually* 2, 3, *or* 4 *years old,* and has been subjected to . . .
2. *Persistent or repeated violence* at the hands of . . .
3. *Either or both parents, or guardian,* who . . .
4. *Fail to report,* or *delay reporting injury* they must have been aware of, and who . . .
5. *Affect ignorance* of or *offer misleading explanations* for the injuries, and who are usually . . .
6. *Inadequate* or *sub-normal* or *simple,* if cunning, but seldom under medical care for mental disorder.

It is most interesting that unlike many "syndromes", this one has usually got all its features. It should be easy to recognise, but it is not because (a) it needs a constant awareness on the part of those around, and (b) clinics, doctors, nurses, police are deliberately mislead by lies designed to throw them off the scent. After all, this is what happened to Caffey himself.

COMMON INJURIES—AND EXPLANATIONS

The common injuries are:—

multiple skin bruises of varying date; split lips and bruised scalps, the latter, with more serious brain injury* and intracranial bleeding. Deep body injuries—split liver, ruptured spleen. Multiple fractures—skull, ribs, long bones—of varying date; "pulled" epiphyses.

and the explanations are:—

"Fell out of pram, out of parents' arms, out of cot, over

*In a survey of 302 cases in America 85 children suffered permanent brain damage.

furniture, down stairs, on to grate or fender." Other children are "always knocking it about". Parent "stumbled and fell with child" in its arms, often downstairs, or just "dropped the baby". Or sometimes—"it keeps coming out in bruises" . . . or just "I don't know how it could have happened".

—when in fact, in my own experience, the ultimate truth that has emerged has been one or more of the following:—

Child *slapped, punched, kicked, gripped forcibly, flung* back into cot, on to bed, floor or across room, around caravan, "*bounced*" on the floor, thrown downstairs . . . *beaten* with strap, buckled belt hung with brass ornaments, switch, cane, broom handle . . . *bashed* with coal shovel, "stiletto" shoe-heel, hammer—or—
gripped by the body or legs and bashed against the floor, wall, furniture, banister, etc.

In another case a child was held forcibly against an electric fire; a father slapped a child so hard it was blinded; another indulged himself in what the magistrate described as "quite disgusting cruelty", burning the baby's face, breaking one of its legs and one arm—and cutting into the tongue to stop it crying. In that case a police inspector said that after a four hour questioning the man had said "It never took to me, that child; always upsetting me, making my turns come on".

These do not, of course, list the possibilities: they are examples of what has come to light when, the injuries having been discovered, a proper explanation is demanded and those seeking the truth of the matter have refused to be put off by some facile tale. Even solicitors are deceived by their clients and may genuinely plead that the doctors "must be mistaken" or are "exaggerating their case".

HOW FREQUENT IS IT?

No one has any real idea—yet, how common this problem is, but in an American survey 749 cases came to light in one year; an Ontario State questionnaire identified 302 cases in a 71-hospital survey. 33 died and 85 suffered permanent brain damage. Something like 10 cases are hospitalized for every one dead—and remember we only see the visible part of this menacing iceberg. My own crime book has a complement of between six and ten cases each year—dead, in and around London, and I am but one of some half-a-dozen pathologists in this field. On one day alone last year, I had a murder charge against a father, and another against a Turkish woman in the Old Bailey, together with a third against a mother at Reading—IN ONE DAY. We do not yet have any nation-wide statistics for England, but the N.S.P.C.C. in its 1966-7 report indicated its intention to set up a London unit, and others are "collecting data". The College of General Practitioners has a "tape" on the subject and hopes thereby to encourage recognition and records.

THE PENALTIES

The present law is hopelessly inadequate unless the child dies: only then, and only if the evidence is good enough to back it up, is a murder charge likely to result in a tough enough penalty. In cases where the parent or guardian is charged at a Magistrates' Court with cruelty or imposing unnecessary suffering, or neglect, the penalty cannot be greater (under existing law) than £25 fine or six months' imprisonment: this is, of course, hopelessly inadequate. I have not written of the intelligence or sensitiveness of the parents, but generally speaking they have been found to fall into psychopathic, schizoid, cold, unfeeling or frankly aggressive types; irritable, labile or depressed, more often of lower intellect and, one would think, quite indifferent to the shame of such a conviction.

What is perhaps more important, are these parents to keep the children they cannot seem to resist knocking about so unfeelingly? Has a doctor the power or the practical means of removing the child to a place of safety? There are two ways open to him; he can always insist on the need to transfer a child whose life is at risk to hospital: to do so he should be able to point to the physical necessity for this —fractures, head injury, suspected internal hurt or bleeding and the like, and the child who is merely "at risk" does not offer him this opening. Here he has the useful alternative of an official request to the child welfare officer, or if he feels that a police uniform might help to warn the parent that he faces the law and not merely the doctor in the matter, then a policewomen—or a more senior police officer in the uniform branch: the latter may prove easier upon application to a magistrate to "remove the child to a place of safety".

The N.S.P.C.C. are also only too anxious to lend their weight when a child is "at risk". This is a new medico-legal problem worth every doctor's best attentions: if he does not remain on the *"qui vive"* it may well be the *"qui meurt"*—too late to help yet another "battered baby".

KEITH SIMPSON

---

60 YEARS AGO

1st October, 1907

The first Pre-clinical students admitted to the Dental School. At that time they were known as Dental Pupils. They commenced their training in Dental Mechanics under the late Mr. Flint in the small laboratory on the ground floor: first door on the right.

WILLS LIBRARY ANTIQUITIES

6. CENSORSHIP AT THE R.C.P.

by William Hill

In 1615 John King, Bishop of London, sent a book on anatomy to the Royal College of Physicians for their opinion of its contents. The Bishop of London, under the Star Chamber regulations, had the task of granting licences to all medical books before publication.

The book in question was *Mikrokosmographia, a description of the body of man,* by Helkiah Crooke. Crooke was born in Suffolk and studied at Cambridge. He applied as a candidate of the College in 1613 and managed to be accepted after a ballot in which he polled 15 votes to 10 against. He was not in good repute with the College having been charged with indiscipline and having on one occasion at least treated the President with disrespect for which he had been made to apologise.

There were several charges against the book. The extreme view taken by some Fellows was that such a book should not be published in English while others considered that parts of it were obscene and that Book 4 on the generative system should be deleted. Others, on the other hand, felt that only some parts of it should be cut out. Another charge was that the book was largely a compilation from two other authors, Laurentius and Bauhinus, and Crooke should make this clear on the title page. It was decided to send two members to consult with the Bishop and to make arrangements for the book to be suppressed or the offending parts removed.

Ultimately it seems that Dr. Gifford and Dr. Clement were asked to revise Books 4 and 5 and in 1615 the book was published with the corrections and the names of Laurentius and Bauhinus acknowledged on the title page. Some people have said that as far as can be seen there were no alterations except the revised title page and that the book was published as Crooke wrote it. In 1631 a second edition was published and the Wills Library possesses a copy of this.

Crooke continued to be an unruly member of the College and there was trouble when he was elected a Fellow in 1620. Despite this he was appointed Censor in 1627, and remained in the office until 1631. He also became Anatomy Reader in 1629. He resigned in 1635 and retired to the country.

The library also possesses a copy of Laurentius's book, *Historia anatomica humani corporis* and it will be on display with Crooke's. It will be open at one of the illustrations which has a striking likeness to one of the figures on the title page of Crooke's book. Crooke's title page is also worth looking at. The upper part shows a blood-letting scene in one corner and an unknown operation in another. Between these is the Cosmos with concentric circles showing heaven, the firmament with angels and stars, and earth with animals, including a unicorn, and the sea with ships and sea monsters. Two smaller pictures are underneath, one of which is of Adam and Eve while the other is unidentifiable. Holding the title in the centre are Death and Time and flanking these are two figures, one showing blood vessels and the other the viscera. The latter is the one resembling the Laurentius plate. At the bottom of the page is an engraving of an anatomy lesion with the demonstrator lecturing on the contents of the skull.

Caspar Bauhin (1550-1624) was professor of anatomy, botany, medicine and greek in Basel. He wrote a very famous index of botanical literature as well as several works on anatomy including *Anatomica Historia,* in which he discusses the Hebrew myth of the bone, "Luz". He also edited Wolf's great work on gynaecology.

Laurentius (or Andreas du Laurens) (1558-1609) wrote his *Historia anatomica humani corporis* in 1600. He also left a good account of the King's evil or scrofula but his most popular book would seem to have been *A discourse of the preservation of the sight; of melancholike diseases, of rheumes and of old age* which was issued in a number of editions between 1597 and 1630.

Crooke also wrote, or rather compiled as most of it is derived from Ambroise Pare, *An explanation of the fashion and use of three-and-fifty instruments of surgery,* 1631. The Wills Library copy is bound with the *Mikrokosmographia.* It is hoped to show a reproduction of the title page of the instruments of surgery with the other two volumes.

As usual, the books mentioned in this article will be on view in the Library for the next fortnight.

NOTICE

Dental Ball

The annual Dental Ball will be held this year at the Cafe Royal on Saturday 18th November. Double tickets are £5 5s. 0d. (Students £4 10s. 0d.) and may be obtained from Miss Carol Blanks or myself.

I. J. MACKENZIE,
Ball Secretary.

CORRESPONDENCE

Abortion Law

SIR,—I hesitate to write another letter on the subject of the law on Abortion, but the unsigned article* in your last edition is liable, in my opinion, to give rise to the wrong impression. In the article there is quoted the Bill as it first appeared before The House of Commons for its third reading, containing the "social" clause to which the Royal College of Obstetricians and Gynaecologists and the B.M.A. objected. As the Bill read then it was permissible to terminate a pregnancy if there was a risk to the future well-being of the patient or her other children. It is a measure of the influence of the Profession on the House over this matter that the words "future well-being of herself" were deleted before the bill was passed, and it became permissible only to terminate pregnancy when there was a threat to the life or health (physical or mental) of the patient or her other children. The *Gazette* article is inaccurate, therefore, when it states that the Commons agreed "to permit the termination of a pregnancy which . . . is a severe or economic handicap which will disturb the family harmony."

There is, furthermore, no mention in The Bill of the termination of pregnancy resulting from rape or incest. It is true that the clause was retained in which it states that "in determining whether there is a risk of injury to health account may be taken of the patient's total environment," but is it ever possible to determine the risk to health without taking into account *all* the circumstances?

The mortality figures quoted of 0.7 per cent for legal therapeutic abortion presumably were those of 1939. The present-day mortality for therapeutic abortion in National Health Service hospitals is about 1 per 1,000. The maternal mortality is now less than 0.2 per 1,000 and even "multiparity" is shown to be much safer than therapeutic abortion in a proper hospital. Figures which seem to show that the mortality of criminal "back-street" abortion is less than that of therapeutic abortion are based on the assumption that very large numbers of criminal abortions take place. A low mortality for criminal abortions runs counter to one's experience of cases admitted to hospital for haemorrhage, sepsis, uterine perforation and renal failure. Perhaps far fewer criminal abortions are in fact being done and the morbidity and mortality are relatively high.

In conclusion may I point out that the Abortion Bill has been amended in the House of Lords and the indications for legal termination of pregnancy even further restricted. One of the practitioners advising termination must be a consultant and it is not permitted to operate because of a risk to the health of the patient's other children. Whether or not these changes will be reserved when the Bill goes back to the Commons remains to be seen. Both Houses are agreed, however, that two doctors must form an opinion in good faith before an operation may be legal, that the operation must only be done in a hospital or nursing home approved for the purpose by the Ministry of Health, that all operations must be notified confidentially to the Chief Medical Officer at the Ministry and that any doctor may refuse to terminate a pregnancy should he object to doing it on grounds of conscience.

Yours, etc.,

T. L. T. LEWIS

109, Harley Street,
London, W.1.

[*EDS. Unfortunately our correspondent failed to read Passim in the last issue where the matter of authorship was by no conceivable means concealed. As Professor Simpson points out, the words were carefully chosen to show the *progress* being made in Abortion Law.]

College

SIR,—Allow me to thank you and your distinguished contributors for the admirable College Memorial issue.

Although it was admittedly ugly, inconvenient and insalubrious, there must be few Guy's men who learn of the passing of the College without a pang.

Mr. Blaikley mentions the painting by Stanley Cock—I can date this exactly for it was executed and presented to the Externs' Room, I believe at the suggestion of G. D. Eccles, during the time that I was Junior R.O.—March and April 1912—the initials of the firm being shown in the picture.

I wonder what became of it?

Yours, etc.,

T. S. ALLEN

11, Adelaide Cresent,
Hove, 3.

SIR,—All those of us who used to live in the College cannot fail to be interested to hear the news that it is being pulled down.

While many of us used to abuse it, there can be no doubt that it is impossible not to have a warm place in one's heart for a place where one has been happy. For in spite of the hard and unremitting work of the House Appointments, I enjoyed them enormously, and when I said so a few years ago to McNair, he replied "So did I".

Anyone who doubts this may perhaps remember the old saying that the highest rank in the Army (in the opinion of the holder) is that of Lance-Corporal. We were the Lance-Corporals of Medicine, and were immensely pleased with ourselves.

When I was House Surgeon to Mr. (now Sir Heneage) Ogilvie, I had a single room in the College about the size of a bathroom, with a bed that was let down from the wall at night. This in itself was no great hardship (as was also the need for artificial light at all times) for one was kept so perpetually busy that one only went there for the few hours available for sleeping, when one went to sleep like diving into the deep end of a swimming-bath, only to be brought to the surface by Shipcott shaking one by the shoulder with the words "Wanted urgently in such and such a ward". Then one would run through the tunnel to the ward, hoping sincerely that one's wits would have arrived back by the time one got there.

There were frequent complaints about the food, but I have yet to encounter a community of any kind where such complaints were not frequent. Even the Israelites complained about their life-saving manna. Personally, I never found any adequate cause for complaint, and I used to feel sorry for the whole succession of unfortunate caterers that we had while I was there.

One of the depressing features of the College was the presence of the annular concrete passages at every floor-level running round the building, with rooms both sides, and only dimly lit by inadequate windows. One of my best recollections of these, however, was the queer Belsen-like figure of Mrs. Sturgess who spent her life on all fours scrubbing these floors, but who nevertheless had a smile and a cheerful word for everybody.

When I was warded a year or two ago on the top floor of the New Guy's House, I used to look down on the College with its "honourable scars", and was discussing it with the House Surgeon who was looking after me. He said that a patient had asked him what that frightful old ruin down there was, to which he replied "That's where I live!"

Yours, etc.,

J. W. SHACKLE

14, Moneyhill Road,
Rickmansworth,
Herts.

Conn's Syndrome

SIR,—I was interested to read your article about primary aldosteronism and was impressed with the manner of presentation. However, it leaves the reader with some misconceptions and there is one important omission.

Miss Tihanyi describes the full blown clinical picture and suggests that this is shown by the majority of patients. Conn himself (Conn et al. 1965) has demonstrated that this relatively uncommon and that the more usual presentation is as asymptomatic hypertension without gross disturbance of the plasma electrolytes. In consequence a number of patients thought to have essential hypertension may in fact have aldosterone secreting tumours.

No mention is made of severe (often malignant) hypertension as a cause of secondary aldosteronism. This has been well documented by Wrong (1961) and is best known as developing in association with renal artery stenosis. However, it may be found in any patient who has severe hypertension with renal functional impairment. In practice, great difficulty may be experienced in distinguishing these patients from those with primary aldosteronism and it is here that the work on plasma renin levels in hypertension from St. Mary's Hospital (Brown et al. 1965) has been useful. Patients with secondary (renal) aldosteronism have high plasma renin levels while those with primary aldosteronism have low levels. This has been explained on the grounds that renin is liberated from the diseased kidney and, via angiotensin, leads to aldosterone secretion. In contrast patients with primary aldosteronism have sodium retention with suppression of renin secretion. Although, as Miss Tihanyi points out, the cause and effect relationship between primary aldosteronism and hypertension is not fully understood, her suggestion that it due to overactivity of the renin-angiotensin system is unlikely to be correct.

Finally, I should like to question the sentence "ECG will show the typical long low QT interval of hypokalaemia". Surely the cardiographic effects of hypocalcaemia and hypokalaemia are being confused ?

REFERENCES

1. Brown, J. J., Davies, D. L., Lever, A. F., Robertson, J. I. S. (1965). Br. med. J., **2**, p. 1215.
2. Conn, J. W., Cohen, E. L., Dovner, D. R., Nesbit, R. M. (1965). J.A.M.A., **193**, p. 200.
3. Wrong, O. (1961). Br. med. J., **2**, p. 419.

Yours, etc.,

CHISHOLM OGG

Renal Unit,
Guy's Hospital,
S.E.1.

Endocrinology Quizette

SIR,—I write to thank Dr. Maisey for his Quizette on Endocrinology in the last issue of the *Gazette* and to point out that the answer to question Q should have read 1, 3, 5, and not 1, 3.

Raised plasma growth hormone levels were first shown to occur in normal subjects in response to insulin-induced hypoglycaemia by Roth, Glick, Yalow and Berson in 1963 (1). This response was shown to be independent of insulin, glucagon or adrenaline. Since then the measurement of insulin-induced hypoglycaemia has been used as a specific test for pituitary somatotrophic function in this and other hospitals (2).

Yours, etc.,

R. D. SPICER

East Wing,
Guy's Hospital,
London S.E.1

REFERENCES

1. Roth, J., Glick, S. M., Yalow, R. S., and Berson, S. A. (1963). Science, **140**, 987.
2. Stimmler, L. and Brown, G. A. (1967) Arch. Dis. Childh., **42**, 232.

Dental Mechanical Students

SIR,—It is not generally known that prior to 1907 Dental Students received their training in Dental Mechanics as articled apprentices to Private Practitioners. At least two years apprenticeship were required by the G.M.C. Regulations before a student commenced his clinical training. Sixty years ago October 1st saw the beginning of the now normal training of the Dental Surgeon, whereby the whole training is taken at the Dental School, by the admission of the first "batch" of Dental Mechanical Students.

Yours, etc.,

DOUGLAS WAIN

Woodford,
Mount Auldyn,
Ramsey, Isle of Man.

Auxiliaries Again

SIR,—I read with dismay, the letter by Mr. Lux in the *Gazette* of September 16th. Surely a man in such an elevated position as Assistant Secretary of the General Dental Practitioner's Association could have verified the factual content of his letter before permitting it to be published.

As I pointed out in my letter of the 19th August, I am a student. This is a fact, not an admission, Sir, and not something of which I am ashamed, as was implied in Mr. Lux's letter.

Perhaps I could explain to Mr. Lux the difference between an auxiliary and an ancillary. An auxiliary is a girl employed in health centres basically to fill teeth in children of school age and to extract deciduous teeth under infiltration anaesthesia. An ancillary is a term applied to any dental assistant, be it auxiliary, hygienist or chairside assistant. Misuse of these terms can only add confusion to an already complex situation.

My colleagues and I experienced a certain amount of difficulty in understanding Mr. Lux's sentence on the regulations governing auxiliaries. If I have understood it correctly Mr. Lux is fighting to prevent legislation permitting male auxiliaries to be trained. If he studies the Dentist's Act of 1957 he will see that there is no regulation prohibiting their use although no men are being trained at New Cross at present.

Finally may I point out to Mr. Lux that the Auxiliary scheme is certainly no longer an experiment. If he cares to read the Final Report on the Experimental Scheme for the training and employment of Dental Auxiliaries published by the General Dental Council in 1966, he will see that it has been accepted and regulations governing Auxiliaries are now being created.

I repeat I am a student and can perhaps be excused my folly. But surely the dentist is employed for the benefit of the population and not the population for the dentist.

In these days of staff shortages in the School Dental Service, Auxiliaries are providing a valuable contribution in the treatment of children and I hope I have clarified the situation for Mr. Lux and allayed some of his misgivings.

Yours, etc.,

PAUL W. F. LAMBDEN

East Wing,
Guy's Hospital,
S.E.1.

—and Dolls ?

SIR,—Ref. your Passim of the 24th June 1967 *Gazette*, under the heading "That Name Again", e.g. "Gut's Hospital" and "Gavis Hospital" allow me to mention "Boy's Hospital", which was addressed from one of the Overseas Countries, during the 1920's, when no lady students were yet admitted into Guy's.

Yours, etc.,

U TUN AUNG.

3, Dalhousie Road,
Moulmein,
Burma.

[EDS.: *We have another*: "Gary's".]

NURSING SECTION

ADMINISTRATION QUIZETTE

There is a great vogue at the moment for quizzes. Here is a newly-devised one specially made up for those unfortunates who come from overseas to take charge of Guy's wards, and are unaware of some of the finer points of ward management at Guy's. It may be taken as seriously as required.

1. From where would you obtain the following?
   (a) An oxygen tent; (b) An oxygen cylinder, 120 cu. ft.; (c) An oxygen cylinder, 48 cu. ft.; (d) A venturi mask; (e) A polymask; (f) An oxygen gauge; (g) A repair job to the wall oxygen fitting.

2. How do you obtain the followiing for a patient at Guy's?
   (a) A bottle of beer; (b) A bottle of brandy.

3. How does the telephone operator know when a nurse has dialled in the case of :—
   (a) Fire (333); (b) A cardiac arrest (0).

4. Where do you obtain the following?
   (a) A large disposal bag; (b) A small disposal bag.

5. Where do you obtain the following?
   (a) A safety razor with two blades; (b) Razor blades; (c) A new electric razor; (d) A replacement for an electric razor that is being repaired.

6. Where do you obtain the following?
   (a) A 7ft. bed; (b) Extension for a 7ft. bed.

ANSWERS

1. (a) Bright or Job. If not available ring Superintendent's Office. After office hours Front Lodge, at night ring Night Sister.
   (b) Domestic Office during office hours. Front Lodge until 2300 hrs. Accident and Emergency department until 0700 hrs.
   (c) Basement Pharmacy.
   (d) Ring Superintendent's Office.
   (e) Medical and Surgical Stores.
   (f) Basement pharmacy.
   (g) Ring Works Department, who contact Oxygenaire.

2. (a) A bed letter with written consent from a Registrar has to go to the Superintendent's office for stamping. This goes to the food stores with a Malt and Liquor order.
   (b) A bed letter with written consent from a Registrar has to go to the Superintendent's office for stamping. This goes to the food stores with a Wine and Spirit order.

3. (a) A red light shows on the switchboard.
   (b) He doesn't.

4. (a) Domestic Office.
   (b) Central stores.

5. (a) S.C.C.D.
   (b) Medical and Surgical stores.
   (c) Through Mr. Burfoot. (Clerk to the Governors.)
   (d) Guild of Ex-Patients, St. Thomas' Street.

6. (a) Works Department.
   (b) Central Stores.

SPORT

RUGBY FOOTBALL

Undoubtedly Guy's had the ability to beat a very strong Blackheath side, but their two tries and two penalty goals were not sufficient and Blackheath's more competent kicking gave them a goal and four penalty goals. Guy's keenness in playing against a very competent front-row allowed them to be repeatedly penalised for scrummaging infringements, and Eaton for Blackheath provided his side with valuable points.

Although six points down after 10 minutes, Guy's pulled back and opened their scoring from a fine dummy scissors by Cheesborough who sent Beacham in for a try. It was unconverted. A further penalty goal for Blackheath brought the half-time score to 3—9. Soon after, Elliott kicked a goal.

The second half saw Cheesborough again opening the gap between the Blackheath centres, and Beacham, again receiving excellent service, went over for a try. Again it was unconverted. From 9—9 Guy's enthusiasm cost them dearly and they were penalised for foot-up—an easy kick for Eaton.

However, Guy's were unable to capitalise on the penalties they were awarded, and Elliott's unorthodox round-the-corner kicking, left many spectators amazed. A further interception by Blackheath (as Guy's, desperately trying to score, were running with the ball in their own 25) sealed victory for Blackheath.

Thorburn, showing his outstanding fitness, finished the game with a fine run downfield and, with Blackheath being penalised, Elliott converted.

Noticeably Neville dominated the line-outs and with good services from Swift, the Guy's threequarter line gave promise for many exciting games this season.

Guy's fielded a much weakened XV against Cambridge City (as Price, Cockburn, Neville, Williams and Swift were playing on tour in South Wales with United Hospitals). Despite lack of drive and enthusiasm in one of the most dreary of games, Guy's were able to beat their opponents 16—3.

The United Hospitals competently beat Pontypridd 12—11 and although a combined team performance it was greatly due to the inclusion of John Novak who, in his wing position, scored three tries. Playing against Welsh Academicals, again Novak scored the only points in a 3—3 draw. Novak shortly arrives at Guy's where as a fresher he will read Dentistry, and we hope his services will be available for Guy's (despite his inclusion in the Harlequins 1st XV last Saturday).

Guy's showed again their much improved ability by beating Old Askeans 20—6. This gave the Hospital one of their biggest victories against Old Askeans for many years.

RODDY JONES

Ranked fifth in the world, Roddy Jones returns to Guy's with the two bronze medals he won in the recent Student Olympic Games in Tokyo.

Before departing for Tokyo, he took part in the National Championships in Blackpool, where he was competing to retain his 110 yd. and 220 yd. backstroke titles that he had won last year while captain of the Great Britain Swimming Team. He retained his 100 yd. title with a magnificent performance.

In Tokyo he took his bronze in the 110 yd., being beaten by two United States swimmers—one who broke the Word Record in the heats and the other who broke this new World Record in the final! As part of the 4 x 110 yd. Medley relay team he again was awarded a bronze medal.

Roddy Jones has already been included in the 1968 Olympic Training Squad, and the Guy's Swimming Club especially would like to join us in congratulating him on his performance and to wish him luck in Mexico.

TRAINING IN EARNEST

The Soccer Club this season shall be competing in the Premier Division of University of London and have started the season with a few friendly games. An intensive training week-end at Thatchings from October 6th to 9th, and the Fresher trials on October 5th, are hoped to provide Guy's with a strengthened side.

The Hockey Club found a pre-season training session with Teddington most inspiring. This talented side, with many County players, sparked ample enthusiasm into the Guy's XI.

DIARY

RUGBY

Sept. 30. Sidcup—H.O.P.
Oct. 7. United Services Portsmouth—Portsmouth.
„ 14. Cambridge University—Grange Road.

FOOTBALL

Sept. 27. R.M.A. Sandhurst II. H.
Oct. 4. Brighton Line and Sussex G.S. A.
„ 7. Sussex University. A.
„ 11. U.H. Trials at Cobham.
„ 14. †L.S.E. H.
†Denotes University League Fixture.

Correction.—We offer our apologies for a printing error in the recent issue of the "Gazette". J. H. Newman was awarded a Full Blue for Lawn Tennis.

HOSPITAL INFORMATION

APPOINTMENTS VACANT

GUY'S HOSPITAL MEDICAL SCHOOL

Applications are invited for the post of **Assistant to Director of the Paediatric Department,** with duties to commence in December 1967, and appointment until 30th September, 1968, in the first instance. Applicants should hold higher medical qualifications and have held a post as Senior Registrar in the speciality in a teaching hospital. Salary is in the range £2,590—£3,050 per annum, plus superannuation. Forms of application are obtainable from the Dean, Guy's Hospital Medical School, and should be returned not later than **21st October, 1967.**

GUY'S HOSPITAL, S.E.1.

Applications are invited for the post of **Senior Registrar in Diagnostic Radiology to the Guy's Hospital Group.** Duties to commence as soon as possible and appointment until 30th September, 1968, in the first instance. Applicants should hold the D.M.R.D. A higher medical or surgical qualification would be an advantage. Forms of application are obtainable from, and should be lodged with, the Superintendent, Guy's Hospital, not later than **16th October, 1967.**

PASS LISTS

ROYAL COLLEGE OF SURGEONS OF ENGLAND

Final F.R.C.S.

N. J. Barwell
M. E. Cavendish
W. S. C. Cox
T. E English
J. V. Kemble
N. J. Knight
A. B. Richards
G. A. Willett

Primary F.R.C.S.

M. H. Jourdan
T. G. Nash
R. J. Parker
S. M. Patient
P. C. Smith
R. L. Strickland
K. J. W. Taylor
N. W. D. Walshaw

ROYAL COLLEGE OF SURGEONS OF EDINBURGH

F.R.C.S.

T. A. H. English
R. A. Sells

CONJOINT BOARD

D.A.

T. E. J. Healy
J. P. Sedgewick
I. A. Sutherland

CHANGES OF ADDRESS

Dr G. Dixon, Ph.D., F.R.C.P.(Ed.), F.R.C.O.G., Department of Obstetrics and Gynaecology, Southmead Hospital, Bristol. Tel. No.: 628974.

Mr. and Mrs. J. D. Ellis, The Surrey Dispensary, Trinity Street, S.E.1. Tel: HOP 0521.

Dr. and Mrs. Andrew Fairley, Woodclose, 137, Nottingham Road, Ravenshead, Notts. Tel: Blidworth 3308.

Dr. and Mrs. J. L. Horrington, "Denholm", Avenue Road, Cranleigh, Surrey. Tel: Cranleigh 1153.

Dr. D. M. Lewsey, Director of Medical Services, Jesselton, Sadah, Malaysia.

Dr. S. R. Meadow, Department of Paediatrics, The Children's Hospital, Ladywood Road, Birmingham 16.

Dr. Rosalind A. Millis, 12, Cardinal's Walk, Hampton, Middlesex. Tel: 01-979 2608.

William Edward Nelson, L.D.S., R.C.S. England, 2, Milburn Drive, Moulton, Newmarket, Suffolk. Tel: Kentford 461.

Dr. and Mrs. Alan Ness, 61, The Drive, Leeds 8. Tel: Leeds 661744.

Mr. Felix Tomlyn, "Ashurst", Ham Manor Way, Angmering, Sussex. Tel: Rustington 3066.

PERSONAL

BOURNEMOUTH, HANTS. Required, an assistant for fully-equipped second dental surgery. Salary on percentage basis. Full clinical freedom and chairside assistance. Box No. 9/2.

BIRTHS

BARWELL—On 22nd August, at Guildford, to Anne (née Thomas) and Nick Barwell, a son, Paul Andrew, a brother for James.

HOLDEN—On 13th June, 1967, to Gillen and Christopher Holden, of 16, Bifield Road, Stockwood, Bristol 4, a son, Patrick John, a brother for Wendy, Julia and Timmy.

PRITCHARD—On August 7th, to Ann (née Tapper) and Flying-Officer David Pritchard, R.A.F., a son, Christopher Paul.

VALENTINE—On September 20th, to Catherine Mary (née Birles), S.R.N., S.C.M. and Dr. Anthony S. Valentine, a son, David Simon, a brother for Alison, Pamela and Michael.

DEATHS

McCALLUM—Suddenly on September 4th, 1967, at Kitchener, Ontario, Canada, Alan G. McCallum, M.B., B.S., D.L.O., aged 42 years.

STEVENS—On 8th August, 1967, John Greet Stevens, M.R.C.S., L.R.C.P. (Surgeon Lieutenant Commander, R.N.).

Readers are reminded of the reduced rates of subscription available for the first three years after qualification.

We would like to remind our readers that all copy for inclusion in the Gazette mut be received eight days before the publication date.

Personal notices one shilling per word (Minimum £1. 1s 0d.)
Birth, Marriage, Death and Change of Address notices are without charge to subscribers.
Non-subscribers will pay £1. 1s. 0d. for all notices other than Personal.

GUY'S HOSPITAL GAZETTE

EDITORS D. S. ROBINS and C. B. BROWN
SPORTS CORRESPONDENT J. G. PAYNE
NURSING CORRESPONDENT E. A. MALPAS

FORTNIGHTLY TWO SHILLINGS VOLUME 81 NUMBER 2067

The opinions expressed in these columns are solely those of their authors and are not to be taken as the views of the Hospital as a whole.

PASSIM

Genesis

It is said that about one out of ten applicants to Guy's gain entry. This may be a slight overestimate but nevertheless reflects the tremendous competition that exists for applicants. Those who are accepted are then informed that, as university students, they are the cream of the nation's educated young—the top 3 per cent, no less. Much has been made of the difference between school and university, and before and on entry the new student is inundated with advice, cautions and directives by aunts, uncles, parents and teachers—the significance of all being lost upon the excited entrant.

Guy's, he will know or be told, is a leading teaching hospital with many traditions, whose name has been carried across to all corners of the world and associated with those of its famous clinicians, Addison, Bright, Hodgkin, Astley Cooper, etc. Its methods of instruction are well tried and well ingrained, and like all great institutions its traditions, though great, often hamper its progress.

The training you, the newly-fledged student will get here will not be a scientific one, it will be to develop your ability as an observer, to teach you to unearth information, signs and symptoms that are hidden to the casual investigator. In short, it will try to equip you with the facility to understand and diagnose with as little laboratory support as necessary. In truth, you will be a clinician whose laboratory is his mind fed by his eyes, ears, hands and a few pertinent questions.

For this practice there can be no standardized method of instruction—you are put on a track and to a large extent left to follow it. The attitude is one of *laissez-faire*. Whether you learn or not, whether you educate yourself or not, is up to you yourself. What guidance you are given is minimal.

The hospital is your playground, and it is your privilege to explore and investigate any part therein. You will find the inhabitants keen to show and demonstrate and tell you its secrets.

Look upon your sojourn here not as a conducted tour but as an expedition and exploration, where what you discover and what you

make of your discoveries is dependent upon your initiative, desire and intelligence. If you wait for guidance you will be disappointed and leave with a degree and little else.

All this will need energy, energy constantly recharged by successes of new discoveries; it is a cyclical process, but the initial momentum needs a degree of self-generated energy.

The one drawback of any importance is students' lack of contact with the rest of the university. There is a tendency to cloistered living which with time inhibits growth. Although time wasting in getting there the University of London Union (ULU) is well worth the trip for the facilities it offers.

Remember it's your university, and as a member you are entitled to attend any of its lectures in any subject—London is still one of the leading centres of learning and many famous men and women are members of the University staff. Go and listen to them, see them—use them to satisfy your enquiries.

Mr. Wheeler's Dog(s)

It gives us pleasure to record that Mr. Wheeler has recently been presented with two new dachshunds, Max and Otto II, so that yet another Guy's tradition is being faithfully maintained. May they be with us for many years.

GUY'S DIARY

We offer our congratulations to the following on their appointments:—

Miss June Whitney, M.B. Lond., F.R.C.S.Eng., M.R.C.O.G., Consultant Obstetrician and Gynaecologist to the Mid-Sussex Group of Hospitals.

B. A. Latham, M.B.B.Chir., Camb., M.R.C.P., D.Phys.Med., Consultant in Physical Medicine to the Brighton and Lewes Group of Hospitals.

OCTOBER

17th Tu. Clinical Lecture. Mr. BLACKBURN.
"Carcinoma of the Thyroid."

18th Wed. 12.30 p.m. in the Chapel.
Christianity and Today's World—I.
The Christian Faith—intellectually possible?
Address by Rev. R. C. Lucas.
All members of the Hospital Community are invited to this Service, which will last half an hour.

25th Wed. 12.30 p.m. in the Chapel.
Christianity and Today's World—II.
The Christian Faith—practically possible?
Address by Rev. R. C. Lucas.
The Service will last half an hour. All are welcome.

CURRENT MEDICO-LEGAL PROBLEMS

3. DRINK (or drugs) and DRIVING

Oscar Wilde had the wit to say "Work is the curse of the drinking classes", and jokes about drunks and their behaviour have poured out for centuries—in the club, on the stage and screen, indeed wherever man drank himself silly. But the fun dies when a "drunk" gets aggressive or endangers others: a drunk with a knife or a hatchet—or a car—in his hands can be a killer. His self-control is impaired, his restraint gone: alcohol dampens better judgment—"paralyses the brakes". He is a potential or real menace, and the law of any civilised country has to step in, as it would if a potential killer were "at large". Road safety measures are not new, but they have to change with the times. What was good in the Licensing Act, 1872 about being "drunk while in charge . . . of any carriage, horse, cattle or steam engine" had become an anachronism when the motor-car arrived: the Criminal Justice Act, 1925, and the first Road Traffic Act, 1930—which first introduced the phrase "under the influence"—came and went as vehicles and views changed. And now, after several more Road Traffic Acts and a White Paper on Road Safety legislation 1955-6 (Cmnd. 2859) we have begun to see Parliament enact even more stringent controls and penalties in a new Road Safety Bill.

EXPERIMENT AND TEST

Experiment upon alcohol and driving behaviour—in particular upon the effects of lower concentrations by Drew *et al* in an M.R.C. Memorandum of 1959—made it clear that even restrained "social drinking" might be a substantial factor in the rising numbers of vehicular street accidents and deaths—both in the driver or his passengers and in the pedestrian. A vital slowing of reaction, often observed at 50 to 80 mg. per cent blood level (the equivalent of a recent drink of some 1½-2 pints of beer or 3-4 tots of spirits), might make all

the difference. It was all very well to point out that 600 Home Office Forensic Science Laboratory measured blood levels among frank "drunk in charge" were nearly all in the region of 200-300 mg. per cent. Serious behavioural errors had brought them in to the Station and this was the thick end of the wedge—the exposed part of the iceberg. Goldberg had pointed out that the blood level at which 50 per cent of experimental subjects were judged by clinical examination to be "intoxicated" varied between 80 mg. (in Scandinavia) to 120 mg. (in U.S.A.—where everything is bigger). By the stage at which 95 per cent of subjects were adjudged drunk, the blood figure was usually around 240 mg. per cent. As the alcohol rose, the ratio of accident to non-accident drivers rose.

Alcohol mg. %	Accident drivers	Non-Accident drivers	Ratio
0- 50	77.5	91.3	0.85
50-100	7.1	5.4	1.31
100-150	4.1	1.9	2.10
150	11.3	1.4	8.10

No one doubted that drinking introduced a menace—a risk to pedestrians and other road users—but at what sort of level? Could we impose a "Plimsoll line" over which, without clinical test, a driver could be said to have drunk to a degree that exposed other road users to risk of hurt or death? English law has always argued that a man is responsible for the natural consequences of his actions when it came to inflicting bodily harm. What about drink? Would imposing a maximum permitted level of say 50 or 80 interfere unreasonably with the Englishman's right to "have a drink at the local" or visit his friends in the country to dine—wine and enjoy a party? Something had to be done to curb the increasing number of accidents, and if alcohol *was* a big factor the drinking driver would *have* to be checked—and checked pretty firmly. The first need, if Drew *et al* were right, was to find out what the statistics of road accidents and drinking really were: a lot of cock, the grave menace some M.P.s declared they were, or something in between.

STATISTICS

Police records of personal injury accidents in England show a mere 0.9 per cent of all casualties and 2.1 per cent of all fatalities on the roads to be "due at least partly to drink or drugs". These figures are misleadingly low because of the difficulty of proof. Figures by Jeffcoate showed that the proportion is nearer 17 per cent of all accidents. She showed also that the proportion rose to 62 per cent after 10 p.m. and that in Scotland and Wales where pubs were closed on Sundays the figure was significantly lower than the English. Observers in the U.S.A., Canada, Germany, Sweden, etc., agreed that the danger of accidents increases when the blood alcohol level rises over 50, more sharply over 100 and quite alarmingly over 150 mg.

per cent: it is ten times greater over 150 mg. than under 50 mg. In general, some 55 to 60 per cent of all fatalities did not involve drink or drugs—but some 40 to 45 per cent did, and drivers and pedestrians were almost equally to blame so far as numbers could show.

Statistics must vary, of course, with the locus, the time of day, the person, the drinking habits (and hours) of the country and with the law enforcement standards imposed. If you drive a three-ton potato wagon at 40 or 50 k.p.h. through the suburbs of Paris at 5 a.m. at your usual working Pernod level of 180 mg. you will excite less attention than when extricating yourself from the Savoy U-turn at 11 p.m. after a party at the same level of brandy. There is no such thing as standard predictable behaviour, or circumstances, or cop-attitude, and all statistics are bound to be coloured to some extent: only laboratory analysis methods are near-comparable—and then only when the procedure is sound and the analyst both capable and careful. Suffice that all statistics agree that a substantial contribution to street accident injury is made by drinking (and a few by drugs) . . . not as big a contribution as that by the dangerous fast driver, perhaps, but substantial nevertheless.

DIFFICULTIES IN PROVING THE CASE

Proof of drinking *per se* has never been difficult, and blood or breath samples taken at the time—(never so satisfactorily, the urine at a 4: 3 ratio)—have for years encouraged the law to relate an analysis figure to the amount drunk (often expressed as "the equivalent of a *minimum* intake of X pints of ordinary strength beer of 2X tots of spirits"). It isn't as simple as that, for much depends on the sex (men "take it" better), the weight (great oafs put it away somewhere better than thin ascetics), the concentration (absolute alcohol fixes the mucous membrane), the food already present or being taken at the same time (fats slow absorption), the time that passes (alcohol is metabolised whilst working, exhaled and secreted)—and so on: these are physiological problems.

There is more to it still. People are different even before they drink: they can't therefore be expected to behave symptomatically in the same way at the same blood levels of intoxication (recorded by blood or breathalyser—the Americans have a "boozometer"). We shouldn't expect clinical test to be capable of mathematical interpretation—and the lawyers know it isn't. For a long time police surgeons and doctors in practice used to have to rely on clinical tests for proof that a driver was "under the influence" (1872 Act) or "incapable of having proper control of a vehicle" (1930 Act) or had his faculties "for the time being impaired" (1962 Act). By this last Act Courts were required to "have regard to the results of analysis" and refusal counted against an accused driver in that a jury could be told he had refused—and could come to their own conclusions why.

Doctors were still required to examine "drunks" if a Station

Sergeant thought they might be ill, and it has always been recognised that it requires a doctor in order to: —

(a) ensure there is no disease, such as Parkinsonism, multiple sclerosis, etc., or injury or some other physical defect that might simulate drunkenness.

(b) agree as to the fitness or otherwise of a person to be detained in a police station: a "drunk who has fallen may have dislocated his neck or have a cerebral lesion".

(c) take blood samples: no police officer or analyst may do this.

Now every police surgeon knows that as soon as he gets into the witness box he is in difficulty over proving the *degree* of intoxication. Clinical tests reveal signs and symptoms which both the B.M.A. booklets, variously titled from "Tests for Drunkenness" in 1927 to "The Drinking Driver" in 1965, and a W.H.O. pronouncement agreed were "relatively unreliable". Signs like flushing, a bounding pulse, nystagmus and co-ordination defects, symptoms like nausea or hiccups, slurred speech and behavioural curiosities like kissing the Sergeant affectionately or breaking up the cell furniture might have other explanations. Few lawyers had any difficulty in breaking up the medical evidence into pieces, each of which they could destroy, and so it became common practice to (a) elect to go for trial before a Quarter Sessions jury of one's fellow men rather than take a sentence "summarily" before a magistrate who knew better than to pay more attention to the doctor than to the Station Sergeant, and (b) to call for the support of blood (or urine) analysis. Even these could be tilted at: in my own experience a doctor has sterilized the skin with methylated spirits before inserting a needle or kept the latter in spirit before use! And a shy victim once asked if he could pass his urine samples more privately in a W.C.: he emerged with two bottles filled with a watery fluid of SG 1001 containing (as analysis showed) traces of iron oxide—never in urine unless the apparatus has got very rusty with age!

So now at last the law has been compelled to admit that doctors are best used merely to ensure that a man with a cerebral haemorrhage who has had a drink or two, who has Parkinson's, or has a self-reduced subluxation of the neck with some residual cord or nerve lesion, doesn't get left in a police cell, or wrongly charged with drunkenness: they are also needed to take specimens of blood. The need to rely on a blood or breath alcohol level as a safer index of intoxication became increasingly evident. Sweden had long done so without apparent injustice; others had taken her example. Could we not do so in an effort to stem drink and driving? Thus we are going to try the new Road Safety Act regulations. We know that there is no complete answer to this difficult problem, but this is at least something. We know that we ought to be just, to pay some attention to driving behaviour and also admit to eccentrics—like the Canadian laboratory assistant in Toronto who can drink 40 *ounces* of sherry in three hours and never raise his blood alcohol above 80 mg. per cent. So *NO RANDOM TESTING* of drivers to start with. Only those whose driving has already caused comment or trouble are to be tested, and let us still admit that we might

occasionally do injustice if we rely *solely* on a blood or breath alcohol level.

1967 ROAD SAFETY BILL LAW

Some maximum concentration of blood alcohol had to be fixed, and after much deliberation with help from a B.M.A. Committee that paid due regard to Drew's tests of "a skill resembling driving" at low concentrations, this is to be fixed—if agreed by Parliament—at a statutory maximum of 80 mg. per 100 ml. blood—or its equivalent. This amounts to what might theoretically follow from drinking as little as say 2 to 2½ pints of beer or 4 to 5 tots of spirits: it would in practice be more. It will be an offence to drive, attempt to drive or be in charge of a motor vehicle on a road or other public place—such as the Front Quad, or the Park—"with a proportion of alcohol in the blood exceeding the prescribed limit"—fixed in clause 6 (1) as 80 mg. The Act will maintain the earlier enactment of the 1960 and 1962 Acts of "driving or being in charge of a motor vehicle while the ability to drive properly is impaired by drink or drugs". How shall this be put into force? Well, if a driver has called attention to himself by his behaviour on the road, by driving at the time of an accident, by getting involved in—not necessarily causing—an accident, a police officer may "ask" him to provide a sample of his breath. The clause "empowers a police constable to arrest a driver if (a) he refuses or (b) the breathalyser colour change shows a level above 80 mg. per cent. The driver who, without reasonable excuse—e.g. a broken leg that requires more urgent attention—refuses a breath test is liable to a fine of £50. At the Station (or, it is also to be proposed, in hospital providing a doctor permits) a driver whose breathalyser is "in the green" or who has refused or failed (he may have vomited or spat into the bag) may be invited to provide a specimen of blood or urine. Duplicates are required for accused's satisfaction: he can get his own experts in—if he can find any. The maximum permitted levels are 80 mg. per cent in the blood and 107 mg. (its 4: 3 equivalent) in the urine.

These are the thumbscrews of the law, but they are unavoidable if only because the clinical tests for drunkenness had fallen a prey to defending barristers and the law had become ineffectual in its control of the rising tide of drinking. Compulsory powers—and some scientifically definable limit to drinking—had to come. The Plimsoll line may seem to have been set too low (the Swedes have 80 mg. though the world generally has 100 mg. per cent) but attention had to be paid to the facts that Drew *et al* had established: behavioural defects were seen even at 30 mg. per cent, became common at 50 per cent to 80 per cent, and were usually obvious at 100 per cent—as the world had already admitted: danger existed before clinical "drunkenness' could be established. Whether doctors will respond in sufficient numbers, whether police, scientific laboratory staff—or the prisons—will cope remains to be seen. Two things are certain: the British public will still drink and drive—and accidents will still happen. Let us hope that this new law will help to restrain drinking drivers and reduce the number of accidents.

KEITH SIMPSON

WILLS LIBRARY ANTIQUITIES

7. ALEXANDER GORDON & PUERPERAL FEVER

by William Hill

In the last but one of these notes, John Burton was described as the first to suggest that puerperal fever was contagious. Mr. J. B. Blaikley has since drawn attention to the claims of Alexander Gordon. Although Burton may have been the first to *suggest* the contagious nature of the disease it was Alexander Gorden who *proved* it. Consequently, as an apology to the memory of Gordon, this note will be devoted to his book, *A treatise on the epidemic puerperal fever of Aberdeen,* 1795.

Alexander Gordon (1752-1799) was born at Strachan, near Aberdeen. He studied in Aberdeen and Edinburgh and after qualification became a Surgeon's Mate in the Royal Navy. After a few years' service he became a pupil at the Lying-in Hospital in Store Street. After several obstetric appointments in London, including the Westminster Hospital, he returned to Aberdeen. Shortly after the publication of his book he was recalled to the Navy. Unfortunately he contracted tuberculosis and was invalided out and died shortly afterwards in 1799.

Puerperal fever was known to the ancients, and Hippocrates mentions several cases. Fever as the result of wound infection was known to Harvey, Willis, Boerhaave and other writers of the seventeenth and eighteenth centuries. Charles White, in his *treatise on the management of pregnant and lying-in women,* 1773, made important observations. He viewed puerperal fever as the result of retained lochia and devised a special bed for obstetric use in which the patient was nursed sitting up. Thomas Kirkland, in the following year, made several observations including the announcement that fever is a symptom and not a disease. John Clarke, in 1793, recognised the importance of cleanliness.

No one had published an epidemiological study until Gordon's book. It was based on his experiences in the epidemic which occurred in Aberdeen in 1793. He discusses the resemblance of erysipelas with puerperal fever and describes how patients admitted with wounds develop erysipelas in the surrounding area. He points out that, in puerperal fever :

> women escape it till after delivery, for, till that time, there is no inlet open to receive the infectious matter which produces the

disease. But after delivery, the matter is readily and copiously admitted by the numerous patulous orifices, which are open to imbibe it. . . ."

He goes on to state that

"the cause of the disease is a specific contagion, or infection. I have unquestionable proof. . . ."

He prints a table of patients showing how the infection was passed from one patient to another by the attendants. He says—

"With respect to the physical qualities of the infection, I have not been able to make any discovery; but I had evident proofs that every person who had been with a patient in the Puerperal Fever, became charged with an atmosphere of infection which was communicated to every pregnant woman who happened to come within its sphere. This is not an assertion, but a fact, admitting of demonstration, as may be seen by the perusal of the foregoing table.

"The midwife who delivered No. 1 in the table, carried the infection to No. 2, the next woman whom she delivered. The physician, who attended No. 1 and No. 2, carried the infection to No. 5 and 6, who were delivered by him, and to many others. The midwife, who delivered No. 3 carried the infection to No. 4; from No. 24 to No. 25, 26, and, successively, to every woman who she delivered. The same thing is true of many others, too tedious to be enumerated".

In a few sentences Gordon anticipates Semmelweis who, in 1847, said :—

"Puerperal fever is caused by the conveyance to the pregnant woman of cadaveric particles through the agency of the examining finger"

and later—

"Puerperal fever may be caused by the conveyance to the pregnant woman of putrid particles derived from living organisms through the agency of the examining finger."

Gordon says—

"If in the dissection of a putrid body, a surgeon scratch his finger, the part festers, that is, inflames and suppurates; and if a fever should be the consequence, it is inflammatory in the beginning. In like manner, if putrid matter be applied to the uterus, it inflames that organ and the contiguous viscera; that is it gives rise to puerperal fever, which is ushered in with a cold stage, and succeeded by a very rapid pulse and acute pain in the abdomen."

Why Semmelweis and Holmes received all the credit is one of the mysteries of medical history. Was it just accident or was it, as Mr. Blaikley suggests, the persecution that Semmelweis suffered and his ultimate madness and death from infection which fixed his name in history. Gordon has no such romantic touches.

THORACIC SURGICAL RESEARCH UNIT (1962-1967)

RESEARCH

(E. Procter, Endowments Research Fellow)

Man's impatience with Nature is nowhere better shown than in cardio-pulmonary surgery, and a marriage of anatomy, physiology, surgery and engineering has led to a great flux of new ideas and techniques in this field.

The Thoracic Surgical Research Unit, established by Lord Brock and still guided by him, moved five years ago into new theatres and a laboratory on the fourth floor of the Nag's Head Extension building.

During the early part of this period the Leverhulme Research Fellow, Dr. A. de Bono, was concerned with the problems associated with lung transplantation in an effort to develop an acceptable technique for the time when the limiting factor of tissue immunity should be resolved. In dogs, some of the transplanted lungs, functioned for many weeks, and one for some months, before rejection. At the end of 1964 the Leverhulme Fellowship was discontinued and the Endowments Research Fellowship became the mainstay of the Department.

The present holder of this post is Dr. E. Proctor. Apart from thesis studies on the effect of certain catecholamines on the coronary resistance of the isolated heart, his main work is concentrated on the development of heart-lung machines and their application to a variety of research projects. In this he has received some support from the British Heart Foundation.

Paradoxically, development of total body perfusion in animals did not match the clinical achievements in this respect, due, in large part, to the "homologous blood reaction" found in many dogs, and satisfactory experimental models for the evaluation of new open-heart procedures were limited to acute work. In 1964-1965 a new bloodless-prime heart-lung machine was devised which allowed of total body perfusion in animals unclouded by the anaphylactoid variable. To date, well over 200 total body perfusions have now been carried out with this machine or variants.

During the last five years, Mr. Ross has pioneered the use of homograft aortic valves from cadavers as a replacement for the diseased aortic valve. The advantages of this method over plastic and steel heart valves has led to a search for a similar, more "natural" type of replacement for the diseased mitral valve. Broadly speaking, there are two main approaches to this problem. One, after the manner of the aortic homograft valve, seeks to replace the damaged mitral valve with another, homograft, mitral valve. Technical difficulties of insertion, and the difficulty of matching dimensions which must be extrapolated from the empty, small heart during by-pass to the full, beating heart off by-pass, have slowed the progress of this apparently simple idea. A second approach under investigation is to ignore anatomy and concentrate on function. To this end a valve which is independent of ventricular attachment has been sought, and this has resulted in the use of aortic valves as mitral valve replacements—either as heterograft (pig) aortic valves with a concealed frame, in dogs, or as a homograft valve without a frame in several patients. The former method, using a concealed ring is technically easier to insert and its competency is assured by the ring, which guarantees the architecture of the valve. Which of these various methods, or their modifications, will provide the final solution, is for the future.

Another promising application of the heart-lung machine is to provide support for the circulation when the heart is failing or has stopped. This technique does not involve opening the chest, and can therefore be applied to various "non-surgical" conditions such as coronary heart disease. A large bore catheter is passed from a femoral vein to the level of the right atrium to divert the venous return to the machine, where the blood is oxygenated before being pumped back into the arterial system via a femoral artery to maintain the blood pressure. At first only suitable for partial support, it is now, in our hands, possible to take over the whole function of the heart and lungs for a clinically useful period of time. To date, in the dog, after arresting the circulation by inducing ventricular fibrillation of the heart with an externally applied electric current, it is possible to maintain the circulation and gas exchange for over eight hours at normal temperature, after which the heart is externally defibrillated and resumes control of the circulation. The animals have survived without apparent damage to the heart, lungs or brain.

The value of this technique in such potentially reversible conditions as cardiogenic shock due to coronary heart disease is obvious, and has been established here in a recent study of total support during experimentally induced myocardial ischaemia and pulmonary embolism. The limiting factor in this technique is likely to be damage to the blood by continual passage through the machine, and future studies will involve the development of both chemical (non-ionic plyol stabilisers) and mechanical (membrane oxygenation) methods of minimising this damage. As the time of useful support is extended a wider range of cardio-pulmonary disorders (respiratory distress of the newborn; aspiration pneumonia, etc.) may benefit.

Related Clinical Application (Alan K. Yates, Senior Thoracic Registrar).

Clinical application in the human patient, directly or indirectly related to these research fields, falls into two main categories :—

1. Application of homograft valve replacement of the mitral valve has been approached from two angles:—

(a) Attempts to replace the mitral valve with a homograft mitral valve have not produced significant results. In a number of patients who have had this performed by both Mr. Ross and Lord Brock, the limiting technical factor appears to be the unresolved problem of ensuring a normally functioning valve. This mainly relates to the critical chordal mechanisms of the mitral valve. There have been no long-term successful results from this type of operation although one patient survived for several months before requiring further valve replacement owing to chordal rupture of the homograft.

(b) The second approach, as has already been noted, is to replace the mitral valve with a homograft or heterograft valve. The function of the aortic valve depends upon its commissural support which, in practice, demands a double suture line or a single suture line associated with a supporting skeleton. Clinically both methods have been applied in the human patient. Recently, Wooler, in Leeds, has published records of a number of patients who have had a supported heterograft aortic valve inserted into the mitral ring with great success. At this Hospital, Mr. Ross has inserted both unsupported homograft aortic valves and pulmonary autograph valves (replacing the pulmonary valve with an aortic homograft at the same time), with very promising results. Our last patient was discharged from hospital at the beginning of August this year with a competently functioning autograft pulmonary valve in the mitral ring.

It would appear that the operative approach to replacement of the mitral valve is about to undergo a radical change where homograft heterograft or autograft tissues will be the method of choice instead of prosthetic valves. The main aim of this programme is to overcome the major embolic problem which arises from the Starr mitral valve despite adequate anticoagulation.

2. Application of closed chest supportive perfusion.

Subsequent to completing a low prime, long-term defoaming capacity bubble oxygenator of larger dimensions suitable for total human body perfusion, closed chest supportive perfusion has been applied to the human patient. This is as yet in the early stages and only five patients have been so treated. The most valuable application of this technique would appear to lie in the support of the circulation in the young coronory patient who shows progressive myocardial failure. It would appear to be especially applicable to those patients with adequate myocardial function which is gradually destroyed by repetitive attacks of ventricular fibrillation from an excitatory focus of a small infarct. The last patient treated by closed chest supportive perfusion was a patient of Dr. Kauntze who, eight days subsequent

to a second coronary thrombosis, developed repetitive episodes of ventricular fibrillation. Despite the repeatedly successful conversion to sinus rhythm, the myocardial instability persisted with gradual deterioration of the patient following each episode. This man was placed on supportive cardio-pulmonary by-pass utilising the common femoral vessels as access to the cardiocascular system. Following the onset of by-pass the myocardial instability immediately disappeared and stable sinus rhythm was obtained. Supportive by-pass was maintained for a three-hour period and during this time stable sinus rhythm ensued, urine output was adequate and the patient regained consciousness. Subsequent to discontinuing the supportive by-pass, the patient's condition remained satisfactory for a few hours but he eventually died in asystole. The encouraging aspect was that, at post-mortem, a very large proportion of the left ventricle was infarcted and this, associated with the previous significant infarction, indicates that in the younger patient with a small irritable focus, supportive perfusion could be a life saving manoeuvre.

The indications are that further experience of this type of supportive perfusion would establish it as a significant resuscitative method in selected cases of coronary thrombosis. It would also appear that this form of cardio-pulmonary support would be of value in resuscitating the critically shocked patient with fluid and electrolyte imbalance and perhaps in the initial treatment of certain cases of pulmonary embolism.

WELCOME TO DENTAL STUDENTS

On behalf of all the members of the staff and of the present students I would like to extend a hearty welcome to those new students who have entered the Dental School this year.

All of you will notice the vast change which exists between your life at Guy's and that to which you have been accustomed while at school. Life at a university puts a student on his mettle; he is given a degree of freedom to which he is unaccustomed and he is treated as an adult who is capable of organising his own life and interests. The student is, of course, expected to work conscientiously of his own volition, but he receives every possible help and guidance in his studies from his teachers.

You will know that Guy's Hospital has a long and proud tradition. That of the Dental School may not be as long but its students have the reputation for giving of their best to all the patients who attend the Dental Department. It is up to all students to maintain and even to enhance this reputation.

It is the hope of us all that your studentship will be enjoyable and that you will make many new friends and that you will participate in the many social activities associated with student life here.

Do not forget that all the members of the staff and everybody in the Medical School Office will help you if necessary, so do not hesitate to discuss your problems with them.

I wish you all a happy and prosperous professional life, and have every confidence that you will maintain the high standards which have been set up by all those students who have preceded you.

F. S. WARNER,
Dean of Dental Studies.

CORRESPONDENCE

Prof. Herbert

SIR,— May I through the *Gazette* express my gratitude for all the gifts and good wishes for my retirement from Guy's which I have received from students, past and present members of the staff and patients.

I greatly appreciate all the thanks and expressions of goodwill which I have received from so many Guy's friends and colleagues and I hope that any whom I have not been able to thank personally will accept this letter instead.

Yours, etc.,

W. E. HERBERT

Newlands,
28, Worcester Road,
Sutton, Surrey.

Communications at Guy's

SIR,— I am sure many of your readers will be interested to learn that Professor Irving Merrill of the University of California, and holder of a Senior Fulbright Fellowship, has chosen to work for a year at Guy's based in the Department of Anatomy. Professor Merrill is Director of the Communications Office for Research and Teaching, and is perhaps the best known person in the field of medical application of television techniques in the United States. Although based in Anatomy he is here to advise anyone who is interested in such techniques, and it is important to add in this connection that suitable equipment, kindly loaned by the Marconi Company, is now sited in a small demonstration room in the basement of the Medical School. Although certain departments who have already developed an interest in such techniques will certainly be using the equipment to a considerable extent, anyone in this medical centre who wishes to try out any presentation of visual information by such means in any form of class or lecture will be most welcome. Professor Merrill is highly experienced in the medical field and would be delighted to advise anyone interested in television usage. During conversations with him it has become obvious to me that he has long since passed the stage of mis-directed enthusiasm, and while every effort would be made to assist anyone with a problem there is no doubt that unsuitable usage will be squashed. It is very pleasing to those of us interested in such development that Professor Merrill should have chosen Guy's as a base, preferring to make the major part of his effort within our centre. He will also, of course, be in considerable demand outside as a lecturer and adviser, being well known amongst British interests as an educationist and expert in the educational television field.

Yours, etc.,

ROGER WARWICK

Anatomy Department,
Guy's Hospital Medical School,

The College and T.B.

SIR,—My residence at the College as Extern, and also during Take-in week were amongst my happiest and most exciting periods at Guy's; but was there not more than a suspicion of T.B. associated with that "dark Satanic Mill"? Two men of my generation developed Pulmonary T.B., and at least two men who became consultants, and there were one or two others whose names I forget. All of these as Housemen would have had a more or less prolonged sojourn at the College, and this particular infection in their cases was surely more than a coincidence?

Yours, etc.,

G. L. DAVIES

Oakfield,
Hay-on-Wye,
Hereford.

Battered Babies

SIR,—With reference to Professor Simpson's article on Battered Babies, I wonder whether our* findings may suggest a possible line of preventive therapy for this tragic situation.

Learning to treat frigidity by psycho-physical methods, we came to see it as an unconscious control system. What needed controlling varied from patient to patient, but often was an aspect of babyishness in themselves, which they saw as frightening and thus intolerable. For some this was dependency itself—for others messiness or noisiness or just "bad" behaviour.

A significant number of such women confessed to projecting this intolerance of their own babyishness into their children, and to "knocking them about" when they revealed the aspect of which they were unconsciously intolerant. When these women could be put in touch with these anxieties within themselves, they improved not only in their sexual performance but in their relationship with their children also.

Yours, etc.,

PRUDENCE TUNNADINE

Grove House,
Leighton Buzzard.

*A group of F.P.A. doctors who have studied and developed the psycho-physical treatment of sexual difficulties for some seven years, by seminar case study methods.

NOTICES

The Ladies' Association is holding a Bazaar on Friday, October 27th, in the Chapter House, St. Thomas' Street, from 11.30 a.m. to 3.30 p.m., in aid of extra comforts for the patients.

Help is required in all forms from as many members and friends of the Hospital as possible.

We hope to collect items for the following Stalls:—

Groceries—Matron and the Nursing Staff.
White Elephant—Mrs. Blaikley and Mrs. Gibberd.
Good as New Clothes (including scarves and children's clothing—Mrs. Stafford-Clark.
Bottle Stall—Mrs. Tomkinson and Mrs. Franks.
Jewellery—Mrs. Siddall.
Christmas Gifts (Cards, Wrapping Paper, etc.)—Mrs. Clarkson.
Toys—Mrs. Mackenzie.
Home-made Cakes and Preserves—The Branches.
Records and Books—Students.
Grand Draw to be organised by Mrs. Warner.
Tea, Coffee and Biscuits to be organised by Miss Janet James, Miss West, and the Southwark Branch.

Please Help to make this a huge success.

You can do this in two ways:—

Firstly, by giving generously to stock the Stalls; secondly, by coming to the Bazaar and bringing your friends and relations.

Help and suggestions to:—Mrs. L. F. W. Salmon, Keat's House, Guy's Hospital.

JANET MCBEATH,
Chairman

Christ and Life

During the latter part of October there will be a special series of addresses given at Guy's on the relevance of Christianity today. The aim of the meetings is to explain the pertinence of the Christian Faith—a Faith that many people reject without serious and open-minded consideration.

Speaker: The addresses will be given by Rev. R. C. Lucas, a Cambridge graduate, who was a naval officer in the last war. At present he is Rector of St. Helen's, Bishopsgate—a Church in the City where a main feature of the work is weekday lunchtime addresses for businessmen, attended by about 500 people. Mr. Lucas is well known in University circles, and he has given similar series of addresses to the Universities of Oxford and Cambridge. He has also lectured in Holland, Canada and, recently, South Africa.

Mondays and Tuesdays in the Anatomy Theatre; Thursdays in the North Lounge, East Wing. All at 5 p.m.

All members of the Hospital Community are welcome. *The addresses have been arranged by the Christian Union.*

ANNUAL DENTAL BALL

The Annual Dental Ball will be held on Saturday, 18th November, at the Cafe Royal. Tickets for qualified persons may be obtained from the Ball Secretary, Dental School.

I. J. MACKENZIE.

NURSING SECTION

The second part of the quiz to help those unfortunates who come to take charge of wards at Guy's.

1. Where do you obtain the following?
   (a) Large specimen cartons; (b) Denture cartons; (c) Sputum cartons.
2. Where do you obtain the following?
   (a) Colostomy plasters; (b) Zinc oxide, Elastoplast bandage, waterproof Elastoplast, etc.
3. How many stores order books are there?
4. Where do you obtain the following specimen pots?
   (a) Universal and urine bottles; (b) Bottles for blood; (c) Blood clotting tubes.
5. How do you order the following?
   (a) Tooth brushes and nail brushes; (b) Small and large bottle brushes.
6. Where do you obtain the following?
   (a) Masks, paper; (b) Caps, surgeons, paper.

1. (a) Basement Pharmacy.
   (b) Central stores.
   (c) Medical and Surgical stores.
2. (a) Medical and Surgical stores.
   (b) Basement Pharmacy.
3. Thirteen
   (1) Requisition for cleaning materials.
   (2) Requisition for crockery and glassware.
   (3) Requisition for hardware and cutlery.
   (4) Requisition for disposals.
   (5) Requisition for surgical items.
   (6) Requisition for printing and stationery.
   (7) Requisition for haberdashery.
   (8) Requisition for medical and surgical stores.
   (9) Requisition for food stores.
   (10) Dry dispensary order book.
   (11) Malt and liquor order book.
   (12) Wine and spirit order book.
   (13) Miscellaneous requisition book.
4. (a) C.S.S.D.
   (b) Clinical pathology.
   (c) Central stores.
5. (a) On a requisition for cleaning materials.
   (b) On a requisition for surgical items.
6. (a) C.S.S.D.
   (b) Medical and surgical stores.

STAFF CHANGES AND APPOINTMENTS

PROMOTIONS

S/N G. Viney, S.R.N., R.S.C.N. (Guy's 1963-67), to Sister on Diplock Ward.

S/N Bennett, S.R.N., R.M.N. (Maudsley Hospital; Dreadnought Seamans' Hospital, Greenwich), to Sister, York Clinic.

Sister P. Ware, S.R.N., R.S.C.N. (Southampton General Hospital), to Evelina Children's Hospital.

RESIGNATIONS

Sister A. Lindemann, from York Clinic.

MUSIC

Sir Malcolm Sargent, 1895—1967

The Elegant Ambassador of British Music is no more: no longer will he carry symphonic Elgar, Walton and Vaughan Williams and our choral tradition to places as far apart as New York, San Francisco, Tokyo and Melbourne. No more will he mount the rostrum in his beloved Albert Hall to add to his 500 promenade concert appearances.

Sir Malcolm's career could have gone in so many directions. He was a gifted student, becoming at 24 the youngest Doctor of Music in England. Pianoforte lessons followed with the great Benno Moseiweitch. Composition followed. "An impression of A Windy Day" was sent to Sir Henry Wood who invited the young Dr. Sargent to conduct this at the Queens' Hall in 1924. The impressive feature was not the music but the conductor. Sir Henry invited Sargent to conduct again. His early passion for Vaughan Williams' music was evident and he was invited to conduct the premier of "Hugh the Drover", a grand opera. In 1931 his great friend, Sir William Walton persuaded him to conduct another premier—"Balshazzar's feast". In the late '30s Dr. Sargent's fame was at its peak—choral conductor, in demand at home and abroad. During the war the public heard Dr. Sargent, on "Brains Trust" on the steam radio. He was shown to be a lonely man of strict and rigid upbringing.

His rehearsals were meticulous to an extraordinary degree: this often brought him into disrepute with orchestras. Sometimes they felt he was perhaps first a showman and only secondarily interested in the music he was conducting. Other complaints were that his conducting of the classics was routine to a degree and that he had no time for the moderns. At least the latter was untrue as far as English music was concerned: he preferred conducting deep Nordic music—Sibelius excited him (surprisingly, he never appears to have conducted Nielsen): he was also sympathetic to the Russian School—Prokofiev and Shostakovich would appear on his promenade programmes. Undoubtedly he was at his happiest with choral music: it so happens that he bought the best out of his choirs also. One feels that his lack of response to Brahms and Beethoven (at least in later years which is all I ever heard) was linked to his rigid beat and his inability to yield his heart to the music—one always felt this was Sargent's interpretation rather than Beethoven's music.

Sargent was the last in the line of people who believed in massed choirs. We now have authentic Handel with Choir of 40 and orchestra of similar dimensions with harpsichord. Sargent to the end persevered with choirs of 400-600 and massive orchestras with piles of base that produced treacle instead of clarity. He stuck to piano continuo. It undoubtedly had an impact, but a grand Victorian one rather than that we believe Handel intended. He played Bach similarly, and in Mozart would stick to 8 or 12 double basses giving his interpretations a stodginess.

He was knighted in 1947 for his services to British Music—undoubtedly through the B.B.C. Symphony (principal conductor 1950-1957) and through his 20 year promenade stint he had bought serious music—"good music" as he liked to call it—to many people who might never otherwise have heard it. I shall miss his promenade "Gerontius" and his "Gilbert and Sullivan".

His discography was small. He leaves recordings of "The Messiah", "Eroica", and Schubert's "Unfinished". This month EMI have re-issued his "Pirates of Penzance" and "Trial by Jury"—these are a real must at one-third of the original price, in excellent stereosound, too. Delius appears too—appropriately with Miss Jacqueline Du Pré in the 'Cello Concerto and the Songs of Farewell.

SPORT

RUGBY

Guy's XV has much need for some extra weight in the pack. A very potential threequarter line has yet to receive the amount of ball that it deserves. Three strong packs in recent weeks, in the form of Blackheath, Sidcup and U.S. Portsmouth have seen Guy's prevented from obtaining possesion in the set pieces. However, lineout play has shown Neville, Cockburn and Peace (now that he is fit) competent to cope: and Guy's have developed a much improved technique in rucking with quick return of ball in the loose.

Sidcup fielded a strong side and with a gusty following wind in the first half were quick to score from a long drop goal. W. Davies playing at full-back (as Elliott switched to centre in the absence of Cheesborough) exhibited fine control of the natural elements by kicking 14pts—thus bringing his personal tally from two 1st XV appearances to 30pts.

Of the many tries that were scored by far the most spectacular was the result of a close passing movement along the touch line, in which Curson was involved three times and Peace eventually 'dived' over to score. A further drop goal by Rowlands brought the final score to 28-3.

The match against U.S. Portsmouth showed Guy's outplayed in the set scrums and also in the line-outs where Eastwood and Thorpe took all possession for the Navy. Novak made his debut for Guy's and proved that given ball he is a dangerous threat to any side. Guy's lost 3-6.

Cambridge University must be regarded as the premier game of the season, and we can only hope that Guy's will win enough ball to give Novak, Rowlands and Beacham (top try scorers—5 tries each from 6 games) and Cheesborough and Price the opportunity to bring victory over The 'Varsity to Guy's. Good luck!

This past week has seen United Hospitals play Kent in a 11-11 draw. Hey appeared for Kent and Price, Elliott, Cheesborough, Swift, Voss, Peace, Cockburn, Peter Williams, and Curson played for U.H.

On Wednesday C. Thorburn captained Middlesex against Warwickshire in a 9-9 draw.

DIARY

RUGBY

Oct. 14	Cambridge University. At Grange Road.
Oct. 21	Bedford. At Bedford.
Oct. 28	Tredegar. At Tredegar.

HOCKEY

Oct. 14	South Saxons. A.
Oct. 21	Teddington 2nd XI (10.45) H.
Oct. 28	H.A.C. H.

SOCCER

Oct. 14†	L.S.E. H.
Oct. 18*	St. Thomas' Hospital. A.
Oct. 21†	Q.E.C. H.
Oct. 25*	K.C.H. A.
Oct. 28	U.L. Cup Prelim. Round—Sir John Cass College. A.

* denotes United Hospitals League Fixture.
† denotes University League Fixture.

RUGBY FOOTBALL

GUY'S v. BLACKHEATH

At H.O.P. 7th September, 1967
Result: lost 17—12

This was a game Guy's dearly wanted to win. That they did not was no fault but their own.

Had they only modest success with their place-kicking, they could have achieved the victory of which their all-round play suggested they were easily capable.

As a game it was a mixed bag of frustration, promise and disappointment. Blackheath held territorial advantage in the first half, Guy's in the second. Eaton, the visiting scrum-half, kicked three deadly short-to-medium range penalties.

Elliott missed with as many only slightly more difficult ones. He was successful with two later kicks, but the damage had been done.

Throughout the game the scoring mounted with Guy's never gaining the lead. During the

second half, with Guy's showing the better cohesion and drive, they were frequently repelled because time after time they lost possession and advantage from the set scrum when poised to strike.

There can be few better front-row combinations than Horton and Ostling. Where Guy's did hold distinct advantage was in the line-outs. Despite some strange throwing in, they managed to dominate and provide fast and usually accurate possession; C. Neville jumping and catching particularly well. There was, however, little offensive play from the back of the line-outs.

The halves provided a smooth link—showing the benefit of two years partnership. They had little difficulty in finding each other; Rowlands holding everything that was offered.

The backs as a whole showed what they could do when given the ball quickly enough.

Handling was sure and the passing accurate; Cheesborough having a particularly good game. He has two essential qualities for a centre. He runs straight and does not signal his intentions to the enemy.

Twice he dummied a scissors with Price and again a beautiful dummy and incisive break; Beacham scoring well on both occasions.

In defence they did all that was asked of them, apart from a five points "gift" interception whilst attempting to initiate an abortive passing movement from their own line in the closing stages.

Elliott's positional play and handling was as immaculate as ever. I only hope he can be persuaded to return to a more orthodox style of place-kicking. As a golfer he must be aware of the consistency and confidence that stems from a sound "method".

The pack played vigorously and intelligently in the loose, demonstrating the value of their pre-season coaching and training.

Fitness makes the difference between just winning or winning easily and winning or losing. It evens the chances with strong fixtures and puts the result of lesser fixtures beyond the vagaries of chance and luck.

Blackheath supporters were disappointed that their men did not open the game and run the ball as they had done successfully in their opening games.

That they did not was hardly their fault, but was due to the continuous harassing of their halves by the Guy's back-row of Thorburn Curzon and Neville. They played outstandingly well, hunting together and always backing up each other to good effect.

I feel I must pay tribute to Hugh Burry, not just as a director but as a "performer". Playing out of position, he covered the field from start to finish like a teenager. Rucking like a demon, he still finds time for the fancy stuff as he showed when he cut down Thorne, the B.H. right-winger, half his age and twice as fast, and later in the closing minutes he remained alongside Thorburn as the latter raced the length of the field with the ball. That he did not get the pass he was after can only be put down to the captain not believing his eyes.

He epitomises his own dictum: "give me a Man and I'll make a footballer of him".

M. LINDSAY

FOOTBALL

GUY'S v. ICARUS

Away at Uxbridge Saturday, Sept. 23rd.

Guy's, facing their toughest season yet, travelled to Uxbridge where they played the strong R.A.F. team; Icarus, who share previously beaten teams such as Corinthian Casuals and Sandhurst. Guy's, fielding an under-strength side, were expecting to be heavily defeated.

From the start play was hard and fast. The much stronger and fitter R.A.F. team were surprised when Guy's built up several attacks on both wings. Guy's finishing, however, was lacking and the Icarus goalkeeper was not troubled. McClure was having a terrific game for Guy's and had the opposition running in circles looking for the ball. Icarus eventually settled down and started to play good attacking football. From a corner, a first-time volley sent Icarus into the lead.

Epps and Ward were both running well and had the Icarus defence back-peddling several times, but failed to find the net. The Guy's defence was playing well; Taylor and Lovell were unfailing with their tackles and passing. Just before half-time, an opposition defender broke through the Guy's defence with a rocket of a shot, which crashed against the bar and bounced off the 'keeper into the goal.

The second-half saw Guy's more on the defensive, only to find themselves three goals down after a slip in the defence. Lacking a full forward line to give sufficient support to Ward, it was obvious that the Guy's attack would not make any impression on the Icarus goal.

However, a solo run by Ward saw the long-awaited consolation goal.

A 3—1 scoreline against a side of Icarus's strength should not be regarded as an easy win. Guy's played extremely well and look like having a good season.

D. LINDRIDGE

Guy's: Carter; Davey, Taylor; McClure, Lindridge, Lovell; Jacobs, Epps, Ward, Briggs, Leeburn.

GUY'S v. MANOR SPORTS

At H.O.P. Saturday, 16th September, 1967

Result: lost 5—1

For the opening game of the season, and their first match on their new pitch, Guy's entertained the Dulwich League side, Manor Sports. The home team contained several reserves, fielding only eight of last year's regular first team.

Guy's were slow to settle down, and soon found themselves a goal down when Moore eluded the defence to score. The home attack, led by Bob Davey—normally a full-back—came more into the game. The big centre-forward was troubling the opposition, but despite this, Manor Sports increased their lead through centre-forward Leahy.

Losing 2—0, Guy's began the second half with new spirit, and after five minutes Davey beat Wakefield, the centre-half, to score from the edge of the penalty area. Spurred on by this success, Guy's pressed hard, and for a time were the better side. However, the Hospital team tired towards the end and Manor Sports cashed in on this fact, adding goals through Leahy, Hennessey and Smith.

Despite being defeated, Guy's can take some consolation from their display, which promises better results with a full, fit side.

Guy's: M. Carter; K. Taylor, P. Evans; D. Lindridge (Capt.), I. Nash, R. Lovell; D. Jacobs, G. Farber, R. Davey, I. McClure, R. Leeburn.

R. LOVELL

BOAT CLUB

The Boston Marathon

This annual race is the longest in the world, and extends some 32 miles along the River Whitham between Lincoln and Boston.

Guy's have been contemplating the event for many years, but not until this year were eight stoical oarsmen found to compete in this blister-raising competition. Preparations involved heavily bandaging the crew's hands and upholstering the seats with foam-rubber.

Guy's set off with some trepidation but soon settled down to a comfortable rhythm. The majority of the course was covered at a rating of 25, only increasing pressure and rate to overtake the many slower crews. The crew stopped several times, first to circumnavigate a lock, and later to recharge with water and glucose. The considerable physical discomfort in the latter part of the race was well equalled with the tedium of the surrounding fenland.

The final quarter-mile contained the finest rowing of the day, when the rating was pushed up to 35 to give a most impressive finish.

The result was 3rd out of 89 crews; the winners being the University of London, whom Guy's beat over the first 16 miles by three-quarters of a minute. A most creditable performance by a moderately fit crew.

Crew: Bow, N. Pinckney; 2, P. Moulder; 3, A. Hodgkison; 4, R. Forrest; 5, M. Mace; 6, J. Miller; 7, J. Pook; Stroke, I. Grimble; Cox, T. Kirk.

A. J. HODGKISON

HOSPITAL INFORMATION

APPOINTMENTS VACANT

GUY'S HOSPITAL, S.E.1.

Applications are invited for the post of Anaethetic Registrar with appointment from 6th November, 1967, until 30th September, 1968, in the first instance. Forms of application are obtainable from the Superintendent, Guy's Hospital, and should be returned by 23rd October, 1967.

HOUSE APPOINTMENTS

December 1st, 1967

Applications are invited for the following house appointments due to begin on December 1st, 1967, forms of application giving choice of post in order of preference to be lodged with the Superintendent not later than **October 27th 1967.**

House Surgeons 4
House Surgeon to the Surgical Unit .. 1
House Physicians 5
Throat and Ear House Surgeon 1
House Surgeon to the Thoracic Unit .. 1
Orthopaedic House Surgeon 1
Children's House Physician 1

The above appointments will be for six months and will be open only to pre-registration *candidates applying for their* ***first*** *appointment* and not to candidates seeking their second six months appointment.

Genito-Urinary House Surgeon 1
(Post-registration or second six months
Casualty Officers 3
(S.H.O.)
Resident Obstetrician 1
(Post-registration)
R.M.O. in Nuffield House 1
(S.H.O.) (To commence 1.1.68)
Resident Anaesthetists 2
(S.H.O.)
S.H.O. in General Surgery at St. Olave's 1
Casualty Officer at St. Olave's 1
(S.H.O.)
S.H.O. in General Medicine and Geriatrics at New Cross Hospital 1
S.H.O. in Orthopaedic Surgery at New Cross Hospital 1
Children's House Physician at Evelina Hospital
(Post-registration) 2
(1 to commence 1.12.67
1 to commence 1 2.68)
S.H.O. to the Rehabilitation Unit at New Cross Hospital 1

Anyone interested in a house officer post at an outer hospital should contact Mrs. Webster in the Superintendent's Private Office.

P. J. HELLIWELL,
Superintendent.

October 4th, 1967.

PERSONAL

DENTAL ASSOCIATE with view to partnership required by three Guy's men in East Anglia. Box No. 8/2.

DENTAL ASSOCIATE required by young *principal (Guy's) in Rochester. Pleasant conditions* and top percentage. Brooks, 1, Esplanade, Rochester, Kent. Tel. 41337.

DENTAL ASSISTANT required in old-established south coast practice. Early view to partnership if mutually suited. Young Principal. Box No. 10/2.

CHANGES OF ADDRESS

Frank Ellis, 97, Harley Street, W.1 (Tel: WELbeck 7828).

Dr. and Mrs. Edward C. Lewis, Merlebank, Church Hill, Merstham. (Tel: Merstham 3401)

Group Captain D. C. Light c/o T.P.M.R.A.F. Hospital Akrotiri, Cyprus, B.F.P.O. 53.

Dr. and Mrs. J. K. Moore, Twitten Cottage, Rope Walk, Alfriston, Sussex.

BIRTH

WESTLAKE—On 23rd September, at Kent and Canterbury Hospital to Angela and Roger Westlake, L.D.S., R.C.S.Eng., a *daughter*, Venessa Jane.

DEATH

TROUNCE—On October 2nd, 1967, Thomas Reginald, M.R.C.S., L.R.C.P., L.D.S., of Cheshunt, Herts.

We would like to remind our readers that all copy for inclusion in the Gazette mut be received eight days before the publication date.

Personal notices one shilling per word (Minimum £1. 1s 0d.)
Birth, Marriage, Death and Change of Address notices are without charge to subscribers.
Non-subscribers will pay £1. 1s. 0d. for all notices other than Personal.

GUY'S HOSPITAL GAZETTE

EDITORS D. S. ROBINS and C. B. BROWN
SPORTS CORRESPONDENT J. G. PAYNE
NURSING CORRESPONDENT E. A. MALPAS

FORTNIGHTLY TWO SHILLINGS VOLUME 81 NUMBER 2068

The opinions expressed in these columns are solely those of their authors and are not to be taken as the views of the Hospital as a whole.

PASSIM

The Progress of Angry Looks

Why 1967 should have turned out to be, if we may use the phrase, the year of the flowering of youth particularly in this country is a question which the politicians will readily answer, the journalists sensationalize, the sociologists debate over Nescafé, and at which the youth will merely smile. The size of the revolution is perhaps understandable when the importance of youth traditionally has been minimal in Britain. The Newtonian third principle of thermodynamics applied to social behaviour is however proving itself even if, as yet, mainly in the exhibitive arena.

The main bastion remains—that of more serious activity in commerce, administration, science and in medicine. Whether or not the youthful peak of intelligence is recognised, the lack of experience is held to be of overwhelming importance. The less there is of experience the less likely is the opinion to receive its due attention, as if Experience were a deity rather than a mentor. As enlightenment grows, so further delegation of responsibility occurs, but only possibly to one's own subordinates. Negotiations, requests and even beggings are infinitely more successful when the participants are both superiors, quite apart from the transaction being well within the capabilities of the juniors. So that when a mistake occurs as did recently in this hospital the feature which receives most attention is whether someone else was told even though such action would have had not the slightest reparative effect upon the unfortunate incident.

The structure of this philosophy is based on the promise in-built of easier times with increasing years, a promise to be in one's turn able to by-pass the new generation in the future, a creed of "suffer now that you may persecute later". Wherein is the seed of revolution—a necessarily youthful seed for a necessarily youthful revolution. Advertising, music, clothing and now broadcasting to name but a few, have all considerably been changed. Less successful has been the progress in other fields. Medicine this year has heard the newfound voice of its junior practitioners to an increasing extent. It is a voice to be heard much more in a situation which is essentially dichotomous—major responsibility being placed upon the junior at night, yet using him as a somewhat expensively-trained secretary with clinical and investigating powers severely curtailed at other times. Good training, good discipline (sic). Good medicine, good sense?

The arts have led once again, and its fringes understandably led astray. The core remains as a drive to set aside stratification which serves little purpose, which demands respect for respect's sake and which fails to learn from those who have so recently been taught and now have so much more to return.

It was an artist who gave the rhetorical question : "If Winter comes, can Spring be far behind?"

White Coats

The Students' Medical Education Committee is to be congratulated on its active response to what appeared to be a widespread desire amongst the Guy's students to be dressed in white coats whilst on the wards.

After negotiations with the Medical School Authorities, it was agreed that students should be allowed to wear white coats in the Surgical Wards "for a trial period beginning on October 17th".

That the response to this concession was, to say the least, unimpressive is not a sign of the rejection of white coats by the students, but a condemnation of the way in which it was attempted to introduce them.

The arguments for the wearing of white coats by students are several*. Perhaps the strongest of these is that the suit in which the student travels by train to Guy's, goes to the cinema, and wanders the streets, is not a sufficiently hygienic garment in which to visit patients; especially those who have recently undergone surgery.

An advertising film, made to encourage the use of the services of a Dry Cleaner, showed how filthy a white suit, worn in London, became after only four days. Small wonder that we wear dark suits!

The criticisms of the tentative introduction of the white coat are based on the expense involved. Did the S.M.E.C. really expect students to rush off to buy three, or, as a bare minimum, two white coats with the prospect of the plan to wear them being scrapped in the near future? Did they expect the notoriously impecunious students to willingly pay 2/1d. three times each week to have the coats cleaned?

Why did they not publish a review of the white coat wearing habits of the Greater London Medical Student; negotiate with the Medical School for the laundering of the coats to be payed for by the School or, via the school bill, by those who support us financially; and then repeat the referendum amongst the students on the wearing of the coat?

Were it conclusive and in favour of the practice, then the results of the referendum should be put as a resolution to the Students' Club asking for a directive from the Medical School Authorities as to when and where white coats *will* be worn. Such directives are already issued with regard to the wearing of coats in the dissecting room and other laboratories.

The wearing of clean coats, brown or white, long or short, in the wards can only be to the advantage of the patients, and the slight

**Gazette,* 1967. 13 May, p. 255; 8 July, p. 363.

inconveniences to the students and the sacrifice of a tradition involved in this change will surely not be allowed to outweigh consideration for the patients.

MISS SIDNEY

The funeral took place last Sunday of Miss T. Sidney, who served the *Gazette* for 33 years continuously, first as Secretary and then from 1934 to 1961 as Manager. In addition she served as Secretary to the Guild of Ex-Patients and Friends of Guy's from its inception in 1933 until her retirement in 1965. It was characteristic of her that she was able to perform both sets of duties to the magnificent degree whereby all who came to know her had nothing but respect and admiration for her. We extend our deepest sympathies to her relatives, who will know how much she will be missed by the Guy's community.

GUY'S DIARY

We offer our congratulations to Dr. Hugh C. Burry, M.R.C.P., M.R.A.C.P., D.Phys.Med., on his appointment as Director of Physical Medicine to the North Canterbury Hospital Board, Christchurch, New Zealand. He will take up his duties in October 1968.

OCTOBER

30th	M	1.00	Clinical Lecture. Mr. BLAIKLEY. "Unusual Cases of Endometriosis."
		1.00	Clinical Dental Lecture. Dr. S. KEISER NEILSON (Royal Dental College, Copenhagen). The Dental Theatre. "Forensic Odontology."
31st	Tu	1.00	Clinical Lecture. Mr. CLARKSON. "Modern Mammaplasty."

NOVEMBER

2nd	Th	1.00	Clinical Lecture. Mr. MAYNARD. "Parotid Enlargement."
3rd	F	1.00	Clinical Lecture. Professor J. R. AUDY (University of California Medical Centre). "Measurement and Differential Diagnosis of Health."
		1.00	Clinical Dental Lecture. Dr. T. MARTHALER (Caries Research Institute of Zurich). Dental Theatre. "Clinical Studies on Caries Prevention."
6th	M	1.00	Clinical Lecture. Mr. BATCHELOR. "Congenital Talipes Equino-varus."
9th	Th.	1.00	Clinical Lecture. Mr. GLOVER.
10th	F	1.00	Clinical Lecture. Dr. MACLEAN.

CURRENT MEDICO-LEGAL PROBLEMS

4. MEDICAL RESPONSIBILITY AT LAW

MEDICAL MORALS

Doctors in practice have always been encouraged—if indeed it were necessary—to maintain standards of behaviour in their relations with their patients which would enhance the reputation of medicine. It is not always easy, for men and women anxious about their own or their family's health, are not always tolerant and understanding. Difficulties, misunderstandings, errors in diagnosis and mishaps in treatment lie at the elbow of even the best doctors: and there are others who fall a prey to the temptations of one or more of the "Six A's", the original sins of practice:—

Adultery—arising out of practice relationships.
Advertising—prowess or skill, or touting.
Association with or covering unqualified persons.
Abortion practices outside what is permitted by the law.
Alcoholic excesses or to some other.
Abuse of Privileges, taking liberties over drugs, certificates, or terms of service with the Ministry, neglecting duties, or generally tarnishing the repute of doctors.

These lapses of behaviour are, with the possible exception of drugs and drunkenness, deliberate, and show a wanton disregard for the reputation of medicine that leaves the General Medical Council no option but to admonish or warn a doctor, even deprive him of his right to practise by "erasure" of his name from the Register. Such bad behaviour usually deserves the term "infamous conduct", strong though the adjective may be.

But happily, doctors are generally speaking decent—even dedicated—people whose ethical standards are seldom in question. Patients tempt them, irritate them beyond endurance—almost drive them to relax with drink or drugs, but seldom indeed have real grounds for criticism of their moral standards.

CIVIL RESPONSIBILITY

It is much more likely that doctors will find themselves in trouble and involved in litigation—or threats of it—because they forget in the rush of work to observe certain responsibilities at law.

Consent is a preliminary to any kind of examination or treatment, and except where a patient comes voluntarily for clinical examination and diagnosis it is always wise to pay some attention to it. Where a "casualty" arrives with a fractured finger, consent to set it under some kind of anaesthetic is probably safely assumed to be **"implied".** But a woman who went to a Midlands hospital because she couldn't breath properly through her nose, rightly claimed that a doctor, who without asking her consent pushed a trochar into her maxillary sinus, had assaulted her. **Verbal** consent is unsafe if anything carrying a risk—anaesthetic operation, treatment with drugs capable of side effects—is to be undertaken for if a patient later denies having consented you have nothing to produce with which you can contradict the allegation.

A standard **written consent** form is desirable, and it is well to explain to any patient who can understand—or to parents or relatives—what is being proposed, what will, it is hoped, result from this, and if there are any particular risks, what they are. Consent must mean something. "Sign this form, will you", is not enough. On the other hand, it is probably unwise to warn each patient that any procedure ever designed carries a risk of death—as it may.

Consent to sterilization is absolutely essential: urological surgeons are nowadays being troubled by men who, in increasing number, request sterilization. It is not strictly unlawful, though it used to constitute a "maim" or hurt to do anything that might prevent a man serving his sovereign in war—as sterilization might. Most surgeons avoid the practice.

Responsibility for care of the patient. Once a doctor has accepted charge of a patient he takes a responsibility that ends only with return to health, transference to another doctor or hospital, or death. Patients on a Health list have a right to the doctor's services and he risks complaints to the local Executive Committee, fines and reprimands—or litigation, if he fails to give conscientious and responsible services to his patients. He must be available, turn out when requested, and provide the kind of care and degree of skill that might be expected of him: more would be expected of an experienced consultant than a newly qualified casualty officer. Both may make errors in diagnosis—provided they are made with due care. Accidents may happen to either, and unless these result from carelessness or lack of skill they are not actionable at law.

NEGLIGENCE OR MALPRAXIS

When a doctor fails to show the kind of care or degree of skill that might be expected of him—whether still acquiring experience as a young house officer, or perhaps an expert in his field—mistakes may happen. These are not just accidents, but errors that arise out of a lack of care—not checking the dosage of a toxic or dangerous drugs, not X-raying a suspected fracture or keeping a drunk with a head injury under observation, not ensuring that the correct finger or toe or tooth is being removed at operation. If these errors, arising from

carelessness or indifference or "taking a chance", cause hurt or expense or loss of income—or death—they give grounds for legal action, for recovery of money, for compensation—and civil action usually follows, these days.

These are the everyday cases the Medical Protection Society or Defence Union undertake on behalf of the doctor. Hundreds of them are going through solicitors' offices and either being "settled" or coming to Court for judgment. No doctor can ensure that he will be immune from such action, and with the development of the Legal Aid Scheme anyone can afford to "have a go"—with everything to gain and nothing to lose. Every doctor *must* protect himself by membership of such societies or unions as offer advice, protection, defence and complete indemnity—and for so little outlay. England offers remarkable "cover" in this field, as compared with, say, the United States.

Doctors should never react to abuse or threats by writing letters of justification or defence. Experienced doctors and lawyers are at hand in the Medical Protection or Defence Societies to take these matters out of their hands, write the necessary replies to allegations, conduct discussions as to responsibility or a "quantum" of damages that might settle a case—far better than any doctor or his personal solicitor could. Damages that would cripple many a young doctor are being paid almost every week of the year out of the accumulated funds for such societies. Membership is a *must* for every doctor on the day of qualification.

Professional secrecy is largely a matter of good manners, for it means only that the doctor must keep to himself those personal matters not concerned with public safety that are confided to him by his patients. Only in Court may a judge occasionally insist on a doctor divulging some professional secret, and it would be well to give way—or you may find a tipstaff leading you into the dungeons. A doctor may always ask to write the confidence on a piece of paper and so confine it to the judge and counsel.

CRIMINAL RESPONSIBILITY

Doctors, it was decided by Mr. Justice Avory (long ago in an abortion case), have a duty as citizens to aid the law in any criminal enquiry. I have had a case where a man, escaping from a house where he had been surprised raping a girl, cut his hand—and was rightly reported by the doctor who repaired it; and several others where doctors have reported addresses which they have come to know as "abortion shops"—in one case a pharmaceutical chemist. No doctor should ever contemplate using a Nelsonic eye for crime, or he may be caught in the web of intrigue himself.

As to committing crime, doctors succumb in two professional fields in particular: one is the practice of abortion unlawfully—subject of an earlier article in this series, and the other is the very old problem

of euthanasia. The subject is too long for this short article, but one point is worth emphasising: a doctor has every right to ease his patient's passing by the use of drugs—indeed it is a humane duty to a fellow being. This does not mean that he has any right to kill, for he has not—it would be a criminal act—as Dr. Bodkin Adams was told some years ago. It is the intent that matters, and this was Dr. Adams' saving.

RESPONSIBILITY IN INVESTIGATION ON PATIENTS

In recent years a new problem has arisen from rapid advances in technical methods of diagnosis and the more extended use of powerful drugs in treatment.

Patients are being subjected to diagnostic and therapeutic procedures that introduce more risk of hurt, sometimes even of death, than they might ever envisage as a part of "hospital treatment". Catheters, endoscopes of many kinds, manometers, opaque contrast media, air, radio-active isotopes, etc., are being passed or injected into the body, powerful anaesthetics, mood-changing, cytotoxic drugs, vaso compressors or dilators, anti-histamines, pyralozones, chemical antagonists, truth drugs, are all being put to use for known or empyrical good—often at known risk and with their marginal error in dosage. The epithet "human guinea-pig" is being bandied about and the ever-litigious public is being warned to watch carefully that the doctor's enthusiasm doesn't carry him away.

Is it necessary to discuss diagnostic methods like air encephalography, radio-active isotope tumour location, cardiac catheterisation —well any diagnostic procedure or proposed treatment AND THE RISKS AND CONSEQUENCES with a patient, and to obtain consent before pressing on? It undoubtedly is: both to discharge a legal responsibility towards a patient, and for the sake of the humanity and courtesy that mean so much to doctor/patient relationships, it should always be done.

This does not mean, for instance, that in giving an urgently-needed blood transfusion one should detail all the recorded risks of the procedure, or that in prescribing phenacetin or butazolidin it should be specifically mentioned that the Dunlop Committee has serious reservations about their choice. It means that where there is a common risk it should be mentioned—the risk of facial palsy after removal of an eighth nerve tumour, or jaundice from prolonged "Largactil" treatment.

Accidents where an unwanted complication or a frank accident happens the patient should always be told. "Unfortunately, Mr. X, this treatment sometimes causes jaundice" or "I am sorry to say that during the injection the needle broke—and we shall have to look for it"—these are courteous regrets, not admissions of guilt. To say one is sorry to cause further trouble to a patient is not saying "I made a

mistake", or "I overlooked the possibility", and it does not imply an acceptance of liability at law.

Procedures contributing to the benefit of the patient in the way of assessment carry their mishaps, of course, but these must always appear in a better light than the risks attendant on *test procedures designed solely to advance medical knowledge.* "Controlled" clinical "trials" designed to promote experience of some drug or procedure should always be planned and supervised by a group of competent investigators—never by an individual.

Responsibility for this kind of procedure must always lie in the hands of someone of consultant status whose stature and experience would stand criticism. *Respondeat superior*—"the guv'nor takes responsibility"—is an important legal maxim which would fail the doctor in practice on his own.

KEITH SIMPSON

A LOST FRIEND (C.E.J.W.)

She was as a lacework of human beauty
From life she was savagely torn;
We clutch at the ragged ends,
Remember, and weep forlorn.

Untangible death, unreal thing,
You've scarred the face of beauty,
You've gouged its precious eye,
In age we understand you,

But in fair youth. Just why?
But all the sorrow is all for us
For the dead will shed no tears.
Death has merely shown us,
Has confirmed our deepest fears—
Each of us is alone.

"S"

THE BAN ON WOMEN

In April 1937, an Editorial in the *Gazette* noted "with surprise and mild amazement" a letter to the *Daily Telegraph* by Professor Ryle, advocating that women students should be accepted at Guy's. The Editors had no hesitation in deprecating any suggestion of removing "the ban on women"; and raised "the question as to whether . . . medicine can be taught with advantage to a mixture of the sexes . . . For, though modesty is a thing of the past, women are almost unshockable and blushes rarely seen before the menopause, yet we feel that there are many aspects of medicine that would be difficult to discuss before a mixed audience."

Professor Ryle replied, appalled at a Passim "so conservative, so ungenerous to women, and so Victorian". On discussing delicate subjects at the bedside, he pointed out that the rounds were already accompanied by nurses. "If medical education does not rapidly eliminate false modesty of this kind it fails in one of its essential tasks. It would, in fact, be improper if doctors and students of both sexes were unable to discuss their problems freely and openly together." The Editors insisted that "some institutions . . . specially designed for male education, would lose much of their attraction if they admitted women. . . ."

In May 1937, they still maintained that "Blimps are not always wrong . . . the male mould of thought is not that of the female . . . Guy's has gained in every way by its exclusively male character." There had been a suggestion that six, and only six women students might be admitted. Defiant, the *Gazette* proclaimed "We shall continue to oppose with the utmost vigour the introduction of even one woman student. . . ."

A letter from Harley Street described female students as "a foreign element, a nuisance . . . in the way and there on suffrance," and occasionally even resented. Then, with unanswerable logic, the writer announced: "*It is not easy for a boy of 18 to sit through a lecture on the copulation of elephants and not be disturbed by the consciousness that the audience is mixed.*" — "Guy's has no good whatever to be gained by the admission of a foreign element of female students, but also . . . nothing could be more disastrous to a small clique of female students than that it should be admitted to Guy's."

At this stage, a student wrote in, on behalf of his colleagues, to state that "It is not difficult to appreciate the widespread resentment and disgust caused by the introduction of a foreign body into the 'Spit' and to realise that those who would prefer to work and relax in the company of women form an insignificant minority."

A later Passim admired Professor Ryle for his boldness in making "this revolutionary suggestion", but hoped "most profoundly that it will remain in history just as it is—merely a suggestion". Letters of support flooded in, from as far away as Khartoum.

One letter was from D. Stafford-Clark, who stated that "the basic reason for their continued exclusion is not that they restrain, but that they inspire. One might almost say arouse. . . . Women are, in fact, a disturbing element. This is particularly so in a male community where there is work to be done." "After all, men who blanch when elephantine copulation is mentioned at a mixed lecture would presumably swoon at a sherry party where the topic differs only in the substitution of personalities for elephants. Medicine is so very much bigger than pornography . . . let none imagine these to be the opinions of a misogynist. Nothing could be less true. My opinion of the female sex, both generally and particularly, is quite absurdly high."

Here, for no noticeable reason, the correspondence stops.
Passim, February 11th, 1939: "We do not see ourselves vying with women for appointments for many a long year. We hope." A letter now gave a call to arms: "Never was there a cause where apathy could have less place than in the prevention of one single woman student ever coming to Guy's, for one leads to two, and two to three, and long before the College is pulled down we shall be overrun—man's capitulation will be complete."

At the 1942 inaugural meeting of the British Medical Students' Association, a resolution was passed stating "that this Council approves the principle of the admission of women to all medical schools on equal terms with men."

A letter in the *Gazette* demanded, "What mental claim do they (women) have to enter the profession unrestrictedly?" Another writer, describing medicine as "a madly overcrowded profession," concluded that there was no room for women doctors. "Are men, who have represented the profession since the great age of Athens 500 years B.C. to sacrifice what little remains to them to entirely newcomers?" On a practical point, he bewailed the fact that on rounds "women always get the best places round the beds".

In January 1943, a ballot held at Guy's on the admission of women students showed the majority of students were "opposed to the suggestion that women should be admitted on either a temporary or permanent basis", with the voting 150 to 45. 106 voters supported the admission of women to medicine under a quota system—but no admission to Guy's; 44 supported women having equal opportunities to men in medicine—but not at Guy's, while only 45 supported their admission to Guy's.

A correspondent stated: " 'Frail' is the last epithet that anyone who has had anything to do with women students would be likely to apply to them; for myself, I would rather describe them as ' toughs '." Another described "that black day" on which women were admitted to Guy's as "disturbingly nigh". A Mr. Lewis said that "Most women students would displace a man whose services . . . would be more valuable". But such protests were in vain.

Finally, under Regulations proposed by the Goodenough Committee, the Government announced that in future the payment of grants to medical schools would be conditional on the adoption by the School of the principle of admitting a reasonable proportion of students of both sexes*. Guy's had to capitulate, and eventually women entered the Hospital as students. A plaintive letter from Rawalpindi asked, "What is going to happen to the term ' Guy's Man '?"

*A letter described this as "blackmail of a very crude order, and not to be tolerated" by Guy's, etc.

MICHAEL A. SIMPSON.

NOTICES

MEDICAL HELP IN TANZANIA

Qualified medical help urgently required at the Newala Hospitals in Southern Tanzania to take medical charge for a minimum period of six months. The two small hospitals involved handle a variety of medical and minor surgical problems. One hospital is under the auspices of the Anglican Church and the other of the Tanzanian Government. The present request for help comes from Trevor Huddlestone, Bishop of Masasi.

Although a certain degree of professional experience is desirable, this need not be great and the post itself will offer opportunities for the development of professional skills. Fares would be paid and the salary would be at Government rates. Those interested in further information should contact Mr. D. Chesworth, 9, Court Road, Tunbridge Wells, Kent (Telephone 22006).

GUY'S HOSPITAL SOCIETY, BOURNEMOUTH AND WESSEX

The Annual Dinner will be held on Friday, December 1st, at 8.30 p.m., at the Anglo Swiss Hotel, Gervis Road, Bournemouth. Dr. M. V. Guilmant will be in the chair. All Guy's Medical and Dental Graduates in the Wessex area are cordially invited to attend with their ladies, and may apply to me if not already in receipt of particulars.

P. J. ATTENBOROUGH,
Hon. Secretary.

65, Wellington Road,
Bournemouth.

L.M.G. (London Medical Group)

"Sexual Abnormalities"—Dr. W. Lindesay Neustatter, M.D., F.R.C.P., Consultant Psychiatrist, will lecture at 5.30 p.m. on Thursday, 2nd November, at Guy's.

Staff, nurses and students are invited to attend, and for the place of lecture are asked to see the notices around Guy's.

PETER SIMS.

WILLS LIBRARY ANTIQUITIES

8. SIR THOMAS BROWN, OSLER AND GUY'S

by William Hill

Sir Thomas Browne was born in London in 1605 and educated at Winchester and Pembroke College. After graduation he travelled on the Continent for seven years, becoming M.D. of Leyden. He then returned to England where he lived near Halifax. After some years he settled in Norwich, where he remained until his death in 1682.

Although his contribution to medicine is unimportant, his works survive as English classics. The most important is the *Religio Medici*, "written at leisurable hours and for his private exercise and satisfaction". It circulated in manuscript among his friends, suffering various alterations in the process. In 1642 two surreptitious editions appeared published by Andrew Crooke. The frontispiece showed a man falling off the rock of life into the sea representing eternity. As he falls he is being grasped by a hand emerging from the clouds. The same publisher issued a later and authorised edition retaining the same frontispiece but this time including a longer title and showing that it was authorised by the author.

Sir Kenelm Digby, held in Winchester House by the Parliamentarians, heard of the book and sent to St. Paul's Churchyard to the booksellers for a copy. When it arrived he was in bed, and such was his enthusiasm that he read it all the way through and composed some observations on it which amounted to another book three-quarters the size of the original. This he did in twenty-four hours. Osler's dry comment was that "Sir Kenelm holds the record for reading in bed". The Wills Library has a copy of the sixth edition, which includes Sir Kenelm's annotations.

The book rapidly became popular, and at least twenty editions are known to have appeared during the lifetime of the author. It was translated into Latin, French, Dutch, and German, and editions appeared not only from London but also from Edinburgh and Oxford.

It has kept its popularity over the years and, like Robert Burton's *Anatomy of Melancholy*, is a delightful companion, full of oddities, quotations from a vast array of sources, and with a wealth of observation. Its orthodoxy was attacked, Browne being accused as being a Roman Catholic by some and an atheist by others, while the Society of Friends considered him a likely convert. It was an attempt to combine honest scepticism with a lively faith in Christianity, and

Browne always considered himself as a loyal member of the Anglican Church.

Sir William Osler loved him. When he came to Guy's in 1905 to address the Physical Society, he chose Browne as his subject. The text of his lecture is reprinted in the *Gazette* for that year and is well worth reading. At the same time he presented the library with a four-volume set of the collected works edited by Simon Wilkin (1846) and inscribed them,

"To the library, Guy's Hospital. In grateful recognition of the benefits he has received from the life and works of Guy's men— William Osler."

Browne's other works include *Pseudodoxia epidemica or enquiries into very many received tenets and commonly presumed truths.* It is a collection of old wives tales treated in the light of the science of the seventeenth century. It is a protest against credulity and pleads for accuracy of observation. *Hydriotaphia, Urne buriall* resulted from the discovery of funeral urns at Walsingham. Instead of an antiquarian discussion on the urns themselves, Browne uses his book to meditate upon mortality and burial customs. Throughout, there is a constant reminder of the one certain thing in all lives, and he concludes, "The greater part must be content to be as though they had not been, to be found in the Register of God, not in the record of Man".

With this work is printed a discourse on gardens called *The Garden of Cyrus.* Other works were on Christian morals, and a series of miscellaneous tracts.

Sir William Osler drew up a list of books for a bed-side library. Included in it was the *Religio Medici,* although he could have included several of the others. Who for example could resist the closing passage of *The Garden of Cyrus*?

> "But the quincunx of heaven runs low, and 't is time to close the five ports of knowledge. We are unwilling to spin out our awaking thoughts into the phantasms of sleep, which often continueth precogitations; making cables of cobwebs, and wildernesses of handsome groves. Beside Hippocrates hath spoke so little, and the oneirocritical masters have left such frigid interpretations from plants, that there is little encouragement to dream of paradise itself. Nor will the sweetest delight of gardens afford much comfort in sleep; wherein the dulness of that sense shakes hands with delectable odours; and though in the bed of Cleopatra can hardly with any delight raise up the ghost of a rose.
>
> "Night, which Pagan theology could make the daughter of Chaos, affords no advantage to the description of order: although no lower than that mass can we derive its genealogy. All things began in order, so shall they end, and so shall they begin again; according to the ordainer of order and mystical mathematicks of the city of heaven.
>
> "Though Somnus in Homer be sent to rouse up Agamemnon, I find no such effects in these drowsy approaches of sleep. To keep our eyes open longer, were but to act our Antipodes. The huntsmen are up in America, and they are already past their first sleep in Persia. But who can be drowsy at that hour which freed us from everlasting sleep? or have slumbering thoughts at that time, when sleep itself must end, and as some conjecture all shall awake again."

MUSIC

André Previn

Recently the London Symphony Club entertained André Previn. Mr. Previn is an outstanding example of a musician who is happy in all aspects of music.

He was born in Berlin 34 years ago : it was there that he received his earliest training in classical music. He furthered this in Paris at the Conservatoire and when he emigrated to the U.S.A. he majored in Music at Los Angeles University.

His friends formed a jazz group with Mr. Previn as the pianist; M.G.M. representatives heard them and recorded them. These records caused a major sensation in the U.S.A., hitting the top of the hit parade and staying there. Mr. Previn had orchestrated these jazz arrangements. On account of his skill in this field, M.G.M. invited him to compose film music—he started with a "Lassie" film. Since then he has arranged or actually written 30 film scores. Four of these have won Academy awards ("Gigi", "Porgy and Bess", "Irma La Douce" and "My Fair Lady").

This has given Mr. Previn financial security, thus he has been able to turn back to his first ambition—to conduct a symphony orchestra. His association with the London Symphony began in the recording studio in 1964 with a record of Shostakovich's 5th Symphony. Mr. Previn, last year, made his Festival Hall conducting debut in, of all things, an English symphony—Sir William Walton's 1st (which he also recorded). Public and critics alike were swept overboard by this enthusiastic transatlantic advocacy. He even conducts Rachmaninov symphonies to a full house (not even Mravinsky and the Leningrad Philharmonic achieved this).

He has an ability to extract the best from his players by enthusiasm—his rehearsals are mild by the side of others. He makes sure that any slackness is noted—he noted during a quiet passage without the woodwind in a symphony the other week that these players seemed to be concentrating extra hard on their scores; when he asked why, he was informed that they were in fact looking at the Stocks and Shares page of the daily paper and were licking their wounds—the players were no doubt pleasantly shocked that their act was noted.

In concerts he has superb stick technique, coupled with a musical flexibility. He plays and directs Mozart piano concertos from the keyboard as part of the current practice. His tendency to choose less popular composers for recording is coupled with a modesty ("Why should anybody presented with a choice of Arturo Toscanini, Walter, Klemperer, Kleiber or Previn in Beethoven buy the Previn recording?") His latest aim is to record the complete symphonies of Vaughan Williams with the London Symphony. He has started with the fiery No. 6 and was finishing No. 7 a few weeks ago (Symphony Antarctica).

What of his aims and ambitions? He has recently written a 'cello concert—full length—and is writing a horn concerto for Barry Tuckwell of the L.S.O. He naturally wants to go on writing film music and his first musical hits Broadway later this year. He takes over the Dallas Symphony Orchestra from Sir John Barbirolli on October 1st and he is scheduled to conduct the L.S.O next year at Daytona beach, Florida, in the six-weeks music festival there.

Clearly Mr. Previn is a busy man who has a fantastic potential—one hopes with all his enthusiasm and commitments he will not burn himself out too soon.

HEDLEY BERRY

CORRESPONDENCE

H.O.P.

SIR,—It is a pity that Mr. I. M. Morris cannot take all the credit for forthcoming improvements at the ground at Honor Oak Park.

The condition of the ground, stand, out-houses, and in particular the pavilion, has been a serious concern of the Clubs' Union for some time.

The pavilion was extended between the wars, when the undergraduate population was considerably smaller. Everybody would agree with Mr. Morris that it is inadequate for our present-day needs and will be even more so if the Ministerial directive to increase the undergraduate entry ensues.

However, I am happy to say that some of his demands are already in hand.

Architects have made a survey of the pavilion to devise the most suitable bar extension. It is hoped to do away with the present recess and swing the bar counter through a right-angle, taking down part of the wall dividing the bar from the table-tennis area. It is hoped to make a right-angled bar, open on two sides to the existing tea room.

The possibility of extending the seating facilities by building on to the front of the pavilion over the area now serving as a verandah, is being considered.

As even Mr. Morris will appreciate, all this will cost a considerable amount of money and, despite the saving of the assistant groundsman's salary over a few weeks, this money is not readily available. I am sorry that because we had no groundstaff to cover a short holiday period Mr. Morris found that cold water was so distasteful in the middle of August!

The Clubs' Union is financially independent and relies practically entirely on subscriptions from the undergraduates for survival, and therefore its budget is limited. Perhaps if more undergraduates paid the subscriptions themselves and did not rely on their grants to cover this item, they might feel rather more disposed to helping their own sports facilities, rather than offering destructive criticism and expecting it all to be done for them.

The Clubs' Union, representing the whole hospital, is most appreciative of the efforts put in by the Hockey Club and their friends in helping out so splendidly during the period when we had only one or no groundsman. It is contributions such as these which make the self-supporting clubs what they are, and one only has to look at Old Whitgiftians or Sidcup to see what voluntary contributions can do.

The expenses of the ground do not just cover the obvious, i.e. the wages of the groundsman and his assistants employed to prepare and maintain the pitches for the various sporting activities. Equipment is needed, and recently we have acquired a new 40 in. Ransome mower; this also needs housing, as do the other pieces of machinery; so a new garage was built. Last year two new hard tennis courts were laid; the cost for these items alone being not far short of £3,000.

It is realised that a new pavilion is needed, but this will cost in the region of £60,000, and this sum takes a lot of finding.

I hope, therefore, that your readers will appreciate that only a certain amount can be done each year, and that we are now attempting to improve the pavilion facilities for all. Perhaps later this session I may call for volunteers to help decorate the interior at Honor Oak. I wonder what the response will be.

Yours, etc.,

B. A. Ross
Hon. Secretary, Clubs' Union

Medical School,
Guy's Hospital.

The College and T.B.

SIR,—The letter from G. L. Davies suggesting that the conditions in the College might be responsible for promoting tuberculosis is interesting, but could there be a stronger factor, i.e. the somewhat unhealthy routine expected of House Officers?

Seldom did they get to bed before 2 a.m. and might well have been up all

night for emergencies in the wards, while those on the surgical side "taking in" operated most of the night. It was still expected of them, indeed they did, to muster for the heavy routine of work the following day.

They had little opportunity for leisure or fresh air, no system of off duty, and no holidays unless they could get a colleague to undertake double duties whilst they were away. Studying for higher degrees had to be fitted in, and some coached students to supplement their meagre salaries.

They were happy—yes, I think they had a greater sense of personal achievement; anyway, it was no use to complain. It was like it or else!

Let us fully appreciate that they were constantly amongst infection of all kinds, and apart from any carelessness there might have been in the care of bedding, I wonder if the College was to blame for the amount of pulmonary tuberculosis amongst the residents?

Yours, etc.,

M. S. GRIFFITH

"Moonrakers",
Mawgan Porth,
North Cornwall.

First Dental Students

SIR,—Who were in the first batch of Dental Students who started from scratch in Mechanics at Guy's? I am sure there are many old Guy's men who'd like to know who comprised such an historical bunch. I believe G. B. Pritchard and my own father, R. B. Campion, were two—these are still alive (very much so!) Who were the others, and are they still with us?

Yours, etc.,

PETER C. S. CAMPION

61, Wimpole Street,
London, W.1.

Questionable Administration

SIR,—The recent quizzes in the Nursing Section merely highlight several of the anomalous, one might say iniquitous, aspects of Guy's, of which we can all give examples. (If I go to Casualty after a severe bang on the head, is it really essential to record my name a minimum of five times?)

But how long must we suffer before these things are improved? Is obtaining changes through the Guy's Committee System going to be likened, as was getting changes from the old Admiralty, to making love to an elephant? There is a strong danger of being squashed, it is not much fun at the time, and in any case it takes about two years for anything to happen.

Yours, etc.,

SIMON LANYON

Work Study Office,
Guy's Hospital, S.E.1.

"Outlook"—Guy's Sociology Society

SIR,—We would like to thank Dr. Peter Draper for making Guy's newest society's first meeting the success it was. In the short time available he gave us a very competent introduction to many aspects of modern sociology.

After the talk, many of the unexpectedly large audience partook in the lively discussion, and the whole meeting proved a very heartening opening for the society.

Outlook will hold its second meeting on Tuesday, 31st October, when Douglas Clark, Political Editor of the *Sunday Express,* will give an address entitled "Dissolution of the Family Unit".

Yours, etc.,

SECRETARY TO THE SOCIETY

East Wing.
Guy's Hospital, S.E.1.

Ancillary/Auxiliary

SIR,—The Oxford Dictionary definition of "ancillary" is:—"Subservient, subordinate".

The definition of "auxiliary" is:—"one who is helpful to". So in applying a term to the New Cross girls, either can be used, Mr. Lambden, although I would prefer the former as these girls are supposed to be subordinate to a qualified dental surgeon; supposed to be under constant physical supervision. But are you also aware there are recorded cases where the "supervision" was by means of a telephone?

I am very pleased that Mr. Lambden has drawn attention to the fact that men are not disbarred from becoming auxiliaries/ancillaries, but my argument went deeper.

If Mr. Lambden and his colleagues (who seem to have had a group discussion over my letter) would search the library for a copy of Hansard (July 12th, 1963), and turn to the debate on the Dental Services (Estimates Committee's Report), he will readily understand why I am not happy that Mr. Robinson is now our Minister of Health.

May I give just two quotes from that gentleman?

"Assuming that the report (G.D.C.) is favourable . . . are auxiliaries still to be limited to the school dental service?"

And again: "Does the Minister not think that it would assist the service if dental technicians could be trained to fit as well as manufacture dentures?"

Does Mr. Lambden and his friends still think the B.D.A. was wrong when at an A.G.M. it overwhelmingly passed a resolution forbidding these New Cross dilutees any category of membership of that Association? Can he perhaps understand that in accepting the Final Report of the G.D.C. on the New Cross scheme, both the B.D.A. and my Association made it quite clear we would fight any alteration of the regulations; in view of the quotes I have just given, can you blame us our fears?

Indeed, the B.D.A. have made it clear that they will refuse any adverts for these girls if the regulations are altered. My Association has a firmer stand; we have never accepted adverts for New Cross, and never will.

I have had the opportunity to interview Mr. Robinson, and he suggested that if the remit of these girls was extended, the dental practitioner would be "free" to undertake the higher aspects of dentistry.

Has Mr. Lambden any idea what fees are paid for the "higher aspects" of dentistry? Let him discuss them with his teachers, and they will tell him the ludicrous scale at present. The dentist in the Health Service RELIES on mundane dentistry for his living; take that from him, and he is really in trouble.

I would also commend Mr. Lambden and his discussion group to read the Cohen report on Health Education (1964). They will see they urge an expenditure on the dental side of £500,000 a year. At the moment it is £3,000. I suggest that instead of lauding the New Cross scheme, and denigrating his graduate colleagues, Mr. Lambden fights for an increased dental health education programme.

No, I do not feel Mr. Lambden needs to be ashamed of his position. In a way I am a little jealous; it is only when qualified that you realise just what he has let himself in for!

But equally, he must not think he knows it all. I am sure the two reports I have mentioned were news to him.

But education can often be lacking, even in high places. When I interviewed Mr. Robinson, before his party came to power, he thought New Cross was a graduate dental school!

Yours, etc.,

L. B. Lux,
Assistant Secretary,
General Dental Practitioners Association.

Flat 2,
Heatherlea,
Prescot Road,
Hale, Cheshire.

NURSING SECTION

The Annual Nurses Prize Giving 1966/67

3 p.m. on October 17th, a sunny but blustery day, found the Physiology Theatre full once more for the Annual Nurses' Prize-Giving.

The Chair was taken by the Chairman of the Hospital, The Rt. Hon. Lord Robens of Woldingham, P.C., D.C.L., who made the opening remarks. Lord Robens gave a cordial welcome to the Principal Guest—The Headmaster of Eton College, Anthony Chenevix-Trench, Esq., J.P., M.A. (Oxon.).

Miss S. Platt presented Mr. Chenevix-Trench with a copy of the book "Mr. Guy's Hospital".

Matron then gave her report. Matron welcomed all who were present, and especially the Guest of Honour. Matron pointed out that Eton College and Guy's Hospital have certain common factors—both are historical foundations; both are virtually on the same river bank, and both endeavour to educate young people to a high standard of knowledge and citizenship.

Another welcome went to the Headmistresses, several of whom were there for the first time, and Matron stressed that she has been delighted to welcome many school parties during the year and very greatly appreciated the help of the Headmistresses in allowing the girls to come.

Of the changes in 1966/67, Matron went on to state that it was not yet possible to say that all the essential reorganisation of 1966 had completely settled down, but that it was abundantly clear that the changes made were bringing increasing reward. The problems of the last two years had been as great as any faced by the Nursing Service in its history, and the Hospital would be for all time in debt to those whose industry and determination had surmounted the difficulties of this epoch.

Matron asked the question, "Why then, in common with the rest of the country, are we suffering the National shortage of Staff nurses?"

Firstly, the "Brain Drain" overseas included young nurses for all the same reasons which influence well trained people in every sphere of National life. In addition, young, unmarried girls now feel less tied to their parents than in an earlier age. Parents themselves expect to continue to be mobile, energetic citizens for a far longer age span, and if the daughters wish to go overseas, their problems of returning home at short notice are comparatively negligible. Secondly, the marriage age is younger. Thirdly, commuting becomes more costly.

Matron reported upon the excellency of the recruitment figures for 1967, but emphasised that there was no room for complacency. The numbers of young people in this country who would be attaining the age of 18 would fall steadily and steeply between 1967-1973, and a realistic situation of the National Health Service having smaller resources must be planned for.

Matron stressed her deep concern that appropriate action should ensue.

There was general disappointment that additional post-registered courses had not been implemented due to lack of finance and of accommodation available.

Matron addressed her closing remarks to the nurses by reminding them that the nursing profession holds untold challenge. New spheres were opening in an ever increasing variety of fields. But in whatever sphere they chose to work the essential priorities remained the same: Service, compassion, wisdom and skill.

The Principal Nurse Tutor, Sister Brysson Whyte made her report. Since January, 1967, 225 nurses had entered the School of Nursing, and 19 for post registered courses. The teaching staff was now at full strength with three new members.

Sister Brysson mentioned the internal rotation of night duty for the first and third year nurses, and said they hoped to include the second year nurses next year. Much of the work on this was due to the unstinting efforts of Sister Joan Sawyer.

The aims of the School during the next year were to improve the correlation of theory and practice with the aid of work sheets and extra classes, with the purpose of giving the Guy's patient a more able and efficiently trained Guy's Nurse.

Sister Hilary Smith then gave the Ward Sister's report and quoted the advantage of the Nurses training in the wards—Senior and Junior nurses working together, and because of the hours of duty rotating through morning, afternoon and night shifts, the great advantage of seeing the patient at all times with no less advantage to the patient.

Sister Smith stressed the nurse's care of *her* patients. She concluded by quoting the words of Sir William Gull, "Education is not only teaching, but training the mind so that it may learn".

The presentation of the Awards was then made by Mr. Chenevix-Trench, and this was followed by his amusing address.

Mr. Chenevix-Trench thanked Matron and The Governors for the honour they had done in inviting him to present the prizes. Mr. Chenevix-Trench commented on the coincidence that this week at Eton College all Chapel Services are devoted to Nurses and Doctors.

Both Eton College and Guy's Hospital were institutions of great tradition which could bring strength and good, but there was also the power of evil, too. Archbishop Temple had said that to be the inheritor of a great tradition breeds heroism: but one must guard against the possibility of breeding hardness of heart. However skilled a job it may be—be it nursing or teaching—there is the need to care, and there is always one essential—that of compassion and care for one's fellow men.

Mr. Chenevix-Trench concluded his address with a quotation from Psalm 127. "Except the Lord build the house: their labour is but lost that build it. Except the Lord keep the city: the watchman waketh but in vain."

After Prize-Giving, tea was taken in the Nurses' Home, and nurses and visitors alike had the opportunity of seeing for the first time the beautiful new entrance to the Henriette Raphael Nurses' Home, and the Hall and Sitting Room.

MEDALS, 1966/67

Cazenove Gold Medal—Miss Hilary Spring

Cazenove Silver Medal—Miss Sarah Platt

Cazenove Bronze Medal—Miss Anthea Gordon

Butterworth Medals—
Miss Betty Arnold
Miss Beryl Barker
Miss Brenda Falkner
Miss Susan Parker
Miss Barbara Stair

The Jean Morton Award—Miss Hilary Spring

The Emily MacManus Prize—Miss Nicola Chorley

PRIZE-WINNERS, 1966/67

Miss E. Allom
Miss J. Andrews
Mrs. K. Atkins
Miss L. Bawtree
Miss E. Byles
Miss M. Bunting
Miss A. Clarke
Miss N. Chorley
Miss R. Davie
Miss J. Glynn
Miss A. *Gordon*
Miss J. Haynes
Miss M. Herbert
Miss E. Howard
Miss J. Lacy
Miss L. Lewis
Miss M. Morrison
Miss D. Pereira
Miss S. Platt
Miss D. Price
Miss E. Salmon
Miss S. A. Smith
Miss A. Spiller
Miss H. Spring
Miss R. *Stillie*
Miss C. Stratton
Miss M. Taylor
Miss D. Wright

Evelina Children's Hospital of Guy's Hospital School of Nursing.

Miss J. Gowers
Miss V. Mee
Miss E. Yalden

OBITER DICTUM

"It was estimated that 22 per cent of former smokers had managed to give up the habit."

"Medical News", 23.6.67.

SPORT

HOCKEY

The Freshers' Trial traditionally opens the season at Guy's. This year showed the Freshers to be of a competent standard, and with the already growing number of experienced players from previous seasons, the Club should be assured of a much improved record from the 2nd and 3rd XI's—this would indeed be ample evidence to justify the recent addition of a second hockey pitch at Honor Oak Park!

The "initiating" Sunday match between the Spirochaetes and the Freshers proved that bibacity and perhaps experience always prevails. Suffice to say the Spirochaetes won 4—0.

SOCCER

It seems customary that the Soccer Club should mar their season's performance by a series of defeats early in the season. It is surprising that this lapse should occur as they inevitably recover by the end of the season to retain at least either the United Hospitals' Cup or League Cup, or in fact both. May we propose that last season's string of defeats, lasting until October 28th, may be an unofficial record?

At the U.H. Final at Cobham, S. Watt-Smith, I. McClure, and D. Lindridge were selected to play against West Ham on October 24th.

A professional Coach has been hired for Monday evenings at 5.15 p.m. All are welcome.

SWIMMING

In the Bologna Trophy between England, Wales and Ireland, Rod Jones (Guy's and Wales) took second place to A. Davison of England in the 220 yards backstroke. The match was eventually won by England with 41 points, second Wales 22 points, and third Scotland 21 points.

RUGBY

Although the National Press felt that Guy's first post-war victory over Cambridge University by 8—0 was not worthy of compliment, we can at least pride ourselves that this was a handsome result. Guy's were unfortunate to be playing a weaker Varsity side than is usually encountered, with both the Captain and Freshmen absent. But undoubtedly Guy's held territorial advantage for the majority of the game. Elliott justified regaining his place by kicking a penalty and by converting Guy's push-over try.

St. Mary's victory over Cambridge University later in the week must surely indicate that they must be treated with caution in the forthcoming Cup matches.

Guy's continues to produce an abundance of County players. Thorburn captained Middlesex to a 3—0 victory over the joint County Champions, Surrey. In the 3—3 draw between Sussex and Kent, Novak appeared for Surrey, and Hey, Swift and Neville for Kent. Special mention should be made of Swift, who gained his first County place—in previous seasons Clark (Blackheath) and earlier this season Eaton (Blackheath) have monopolised the scrum-half position.

RUGBY

Oct. 28.—Tredegar—Tredegar.
Nov. 4.—Old Blues—H.O.P.
„ 11.—Wasps—Sudbury.

SOCCER

Nov. 1.—U.H. v. London Insurances. A.
„ 1.—†Kings College. A.
„ 4.—*U.C.H. A.
„ 8.—U.H. v. S. Olympian League. H.
„ 8.—†Q.M.C. H.
„ 11.—U.H. Cup, Round 1.—R.D.H. H.

†Denotes University League Fixture.
*Denotes U.H. League Fixture.

HOCKEY

Oct. 28.—H.A.C. H.
Nov. 4.—Kingston Grammar School. H.
,, 11.—Wimbledon 2nd XI. A.

RUGBY

GUY'S v. SIDCUP

At H.O.P. Saturday, 30th September, 1967
Result: won 28—3

Sidcup, now a force to reckon with in Kent rugby, fielded a strong side with a large pack and several county players. Guy's were forced to move Elliott from full-back to centre in the absence of Cheesborough and W. W. Davies substituted for the former. It was a dry day with a characteristically strong wind blowing down field away from the clubhouse in the first half. Another point of interest was to be the role of the experimental law, penalising sides kicking directly to touch in their opponents' half by a line-out given opposite the point of the touch-kick.

Sidcup were quick to take advantage of the wind and kept play early on in Guy's half. Their positional advantage was soon awarded by a successful long range drop-kick. Guy's were a little taken-aback and also found the heavy Sidcup pack difficult to hold in the tightscrums, when the heel was often shared, and in the lineouts and ensuring rucks. However, it was most satisfactory to see a clean-cut Hospital advantage in the loose where the whole pack were much quicker than the opposing forwards, and much useful possession was obtained—this factor set the style of Guy's recovery, for the threequarters were given room and time to move, and Beacham in particular stretched the cover defence to its limits. Another feature of the break-back and eventual victory was the accurate soccer-styled place kicking of W. W. Davies, when in the difficult windy conditions amassed a personal total of 14 points.

The Hospitals' handling was first a little suspect with the onus too much on the taker of the ball to collect a hard and fast pass. It was for the forwards to demonstrate the need for closer and more carefully given passes in the windy conditions, and it was such passing which resulted in the best try of the game late in the match, when the ball went through several pairs of hands before Peace scored in the corner.

As for the new law, a fine appraisal was difficult in the presence of the strong wind, which made kicking in attack uncalled for. A few kicks with the elements did commit the opposition to make unrewarding returns to touch. In any case it was to Guy's advantage to run with the ball against a slow and less fit opposition, and an earnest threequarter line soon found the gaps, supported by a hard-working back row.

Team: W. W. Davies; R. Beacham, J. Price D. Elliott, P. Bundred; B. Rowlands, P. Swift; E. Neville, G. Hey, J. Logan, P. K. Peace, M. Cockburn, C. Thorburn (Capt), C. Neville, Curzon.

SOCCER

Governors' Shield, 1st Leg
STUDENTS v. STAFF

At H.O.P. Tuesday, 19th September, 1967
Result: draw 3—3

Two changes were made to the student's side for the first leg of the Governors' Shield contest.

The Students' attack soon had the Staff XI struggling, and it came as no surprise when they opened the scoring after five minutes through Lindridge. McClure was bundled off the ball in the penalty area and the captain made no mistake from the penalty spot. Not content with a single goal, the Students soon increased their lead. The Staff goalkeeper did well to push out a long-range shot from Elias, but he stood no chance when Leeburn hit home the loose ball. Spurred on by the presence of their President, the Students well deserved their 2—0 half-time lead.

However, the situation changed soon after the interval with the Staff XI attacking strongly. The Students defended desperately, but could do nothing to prevent two goals in quick succession. When the Staff scored again it seemed to be the winning goal, but Farber equalised with the last kick of the game.

This was an interesting match with a fair result, and also one which promises an exciting second leg decider at the end of the season.

Team (Students): M. Carter; P. Epps, K. Taylor;; D. Lindridge (Capt.), I. Nash, R. Lovell; D. Jacobs, G. Farber, I. McClure, E. Elias, R. Leeburn.

R. LOVELL

GUY'S v. R.M.A. SANDHURST II

At H.O.P. Wednesday, 27th September, 1967
Result: won 6—2

Seeking their first victory of the season, Guy's were hosts to a Sandhurst side containing several first team players.

The opening phase of the game saw Guy's attacking strongly, and the visitors' defence was soon in action. Prompted by Elias, the home side went close to scoring on several occasions, but in fact the scoring was opened by the Sandhurst centre-half who headed into his own net under pressure from the Guy's attack. After 35 minutes, Guy's went further ahead through a goal by Ward, who headed home a through ball from Elias. However, over-confidence resulted in some slack marking in the Guy's defence which Sandhurst capitalised on by scoring after 35 and 42 minutes. So, after controlling the first half Guy's turned round drawing 2—2.

The first twenty minutes of the second half saw Guy's move into a winning vein as a result of scoring three goals in 10 minutes. Lindridge put Guy's into the lead with a deft deflection after 53 minutes. One minute later Elias beat three men in a left wing run before crossing to Ward who viciously hit the ball into the net on the volley. The same player completed his hat-trick after 63 minutes, leaving the goalkeeper no chance with his shot. The home side was attacking continuously but failed on several occasions to take easy chances. Elias completed the scoring with one minute to go when he raced clear of the defence before delicately lobbing the ball over the advancing goalkeeper.

This result was achieved by good teamwork and plenty of running off the ball in which Epps and the inside forwards, Elias and McClure excelled.

Team: M. Carter, R. Davey, K. Taylor, D. Lindridge (Capt.), I. Nash, R. Lovell, D. Jacobs, I. McClure, D. Ward, E. Elias, P. Epps.

R. LOVELL

GUY'S v. SUSSEX UNIVERSITY 1st XI

Fiday, 6th Octoer, 1967

Making their first trip to "Thatchings" the Soccer Club had hopes of playing Sussex University on Saturday, Sunday morning then

travelling to Cobham to play in the U.H. 6-a-side tournament.

After a long, tiring car journey ten members of the team managed to arrive at Thatchings in the early hours of Saturday morning. After being well looked after by Mr. Luckett and his staff, the Guy's team of ten men set off for Sussex University. Several desperate phone calls traced the eleventh man who was half way between "Thatchings" and Brighton five minutes before the kick-off. Delaying the start for as long as possible the game started on possibly the worst pitch in England.

After ten minutes play, the eleventh man arrived amidst great cheers and other comments. Guy's looked quite balanced and were playing well, especially when the ball was visible above the grass. It soon became obvious which way the match was going to turn. One could blame the long journey in crowded cars, the bad pitch or even a superior opposition; but the truth was that Guy's were playing atrocious football, if one could call it football.

The scoreline of 9—0 is of little importance, the important thing is that the team must get fit and start to play sensible football. The Soccer Club is desperately in need of a coach if it is to win a permanent place in the University League.

Only one player deserves a mention and he is Martin Carter, who, despite the scoreline, saved Guy's from being beaten by twice that score.

I hope the team can forget this embarrassment and start to play the game as it should be played.

D. LINDRIDGE

Team: Carter; Davey, Taylor; Poole, Watt-Smith, Lovell; Jacobs, Lindridge (Capt.), Ward, McClure, Hutchinson.

GUY'S v. SUSSEX UNIVERSITY 1st YEAR

Sunday, 8th October, 1967

After an entertaining evening at Sussex University where the Guy's team was nearly converted to the Hippie religion, the Soccer Club once again took the road from "Thatchings" to Brighton. A slightly bewildered side arrived in Brighton for an eleven a.m. kick-off.

Guy's had seven positional changes from the side which was trounced on Saturday. Whether or not the team had been in transcendental meditation on Saturday night remains to be seen, but the side played with renewed spirit. McClure was grafting hard in midfield and was linking well with the new boy, Hutchinson. Ward now playing on the left wing seemed to find some of his lost form and quickly had the opposition defence at his heels. Ward hit a first time cross from the right wing and put Guy's into the lead. Sussex equalised ten minutes later through their centre-forward. Guy's were now playing better as a team, and both wingers were breaking through the Sussex defence. Hard running by Ward eventually paid off when he pushed Guy's back into the lead.

In the second half, Guy's were attacking all the time and should have been further in the lead through Jacobs. The Sussex goalkeeper was playing well and saved several certain goals. In one of their few breakaways Sussex University drew level after a mistake by Carter.

Guy's kept up their pressure until McClure with a brilliant solo effort sent the Sussex defence the wrong way and curled the ball past the keeper. Lack of finishing prevented Guy's from scoring more goals.

If the team is to survive in the University or Hospitals League it must play more open football. Fitness is of prime importance, and every member must turn up for training at H.O.P. on Mondays at 5.0 p.m. if the club is to do well.

Team: Carter, Watt-Smith, Taylor; McClure, Lindridge, Lovell; Jacobs, Hutchinson, Davey, Poole, Ward.

HOCKEY

GUY'S 1st XI v. SOUTH SAXONS

(Away) Saturday 14th October

Result: drew 1—1

On a bitterly cold afternoon Guy's took the field with a fairly similar side to that of last season. The play in the first half was extremely scrappy and undistinguished, the only spark came when Godfrey followed up a short corner and pushed the ball home. Guy's, feeling content after this goal, relaxed, and 30 seconds later South Saxons scored to equalize.

During the second half Guy's made several chances for themselves but the finishing was poor and only one disallowed goal resulted.

Feeling a little disheartened with a draw it was very satisfying to watch the second team win 4—2.

Team: C. M. Calder; M. Vellecott; D. Crafts; R. Kendrick, V. Harvey, C. Pearson; R. Chase, T. Owen, N. Dodd, S. Cripps, A. Godfrey.

S. W. CRIPPS

SPIROCHAETES v. FRESHERS

Sunday 8th October, 1967

Result: 4—0

The Freshers' introduction to the social side of the Hockey Club took place at H.O.P. on the eve of B-Day. The game was preceded by the usual light refreshment in the Miller. The Spiros' were far stronger than the Freshers who tended to lack cohesion. Some good tackling by Nickalls and Milliner prevented the Spiros' from turning their territorial advantage into goals until late in the first half when Cripps collected a loose ball in the circle, and beat Calder easily with a firm shot.

At half time Toplis failed a breathalyser test so Clark was forced to bring the substitute on. The beginning of the second half saw the Freshers attacking the Spiros' goal, ably supported by Sutherland who, confused by the customary change of ends, laid on a fine cross from the left wing. This so amazed both sides that the Freshers were unable to capitalise on this momentary lapse. The Spiros' forwards now were playing as a unit and Cripps scored again. Owen followed his example and capped a fine display by beating Calder with a flick, having dribbled the ball in from outside the "25". The 'Chaetes were now encouraged by a territorial dispute being settled in their favour and just before fall time scored again, Cripps collecting his third.

Of the Spiros', Cripps and Owen played well. Gillingham must be complimented on his stamina and new line in hockey boots. Milliner, Shutes and Nickalls showed promise for the Freshers, and the Club look to have one of their best intakes for many years.

After the game all retired to the pavilion for tea before having a quiet drink to round off a most enjoyable afternoon.

In conclusion, I would like to thank our Vice-President, Dr. C. Hunter-Craig, and our Southern Counties Umpire, M. Knight, for umpiring and all those who came and watched.

Spiros: R. Clark (Capt.), A. Gillham, D. Crafts, J. Toplis, R. Kenderick, C. Pearson, A. Sutherland, R. Chase, T. Owen, N. Dodd, S. Cripps, A. Godfrey.

Freshers: C. Calder (Capt), D. Milliner, R. Nickalls, M. Sarnji, J. Walker, C. Glazebrook, A. Holland, J. Shutes, B. Martindale, M. Bye, B. Jones.

R.W.K.

WATER POLO

GUY'S v. OLD MIDWHITGIFTIANS

Away Wednesday, 4th October, 1967

Result: lost 3—5

Old Midwhitgiftians always field a strong team of fit players, and a good showing against them is a good sign

Guy's were always within range of victory, and if only they had treasured possession a bit more they would have won. Instead of keeping possession and waiting for a chance to put in a really hard shot, going at least for a corner, someone would too often be tempted to shoot from a difficult position. The goalkeeper would accept the gift, and his mate who was on the halfway line, expecting Guy's to score, would suddenly find himself in the limelight with a clear path to the Guy's goal.

In fact, though Guy's had the majority of possession, they only scored two goals as a result of careful strategy; the scorers, Froom and Challacombe. The other goal was a fancy affair, a long pass from Froom being deflected into the net by Davidson.

Guy's: Challacombe, Foulds, Froom, Howard, Davidson, Aspin, Adkins, Northcott, Evans.

HOSPITAL INFORMATION

APPOINTMENTS VACANT

GUY'S HOSPITAL AND SOUTH-EAST METROPOLITAN REGIONAL HOSPITAL BOARD

Applications are invited to fill two established vacancies as **Senior Registrars in Anaesthetics to the Board of Governors of Guy's Hospital and the South-East Metropolitan Regional Hospital Board.** Applicants will be expected to spend two years in the region during a four-year tenure of the post. The appointment will be made jointly by the bodies concerned. The post in the Region will be held in alternate years in the Brighton and Lewes and St. Francis and Lady Chichester Groups. The post, which will be reviewed at the end of the first year, is subject to the Terms and Conditions of Service of Hospital Medical and Dental Staff (England and Wales), with duties commencing as soon as possible. Forms of application are obtainable from, and should be lodged with, the Superintendent, Guy's Hospital, S.E.1, not later than **31st October, 1967.**

GUY'S HOSPITAL, S.E.1.

Applications are invited for the post of **Senior *Registrar in Obstetrics,*** *with appointment from* mid-December, 1967, until 30th September, 1968. Forms of application are obtainable from the Superintendent, Guy's Hospital, and should be returned not later than ***6th November, 1967.***

GUY'S HOSPITAL, S.E.1.

Applications are invited for the post of ***middle-grade Registrar in Obstetrics,*** with appointment from 1st February, 1968, until 30th September, 1968, in the first instance. Forms of application are obtainable from the Superintendent, Guy's Hospital, and should be returned not later than **6th November, 1967.**

ENTRY OF NEW STUDENTS

October, 1967

MEDICAL SCHOOL

First M.B. Students

Allen, C. J.	Eton College
Bevis, C. A.	Rishworth School, Nr. Halifax
Cordingley, F. T.	Oxted County Grammar School
Dornhorst, Anne	Holland Park Comprehensive School W.8.
Edmondson, S. G.	Bromley Boys' Grammar School, Kent
Edwards, S.	Woodhouse Grove School, Bradford Yorks
Lewis, J. P.	St. Paul's School, West Kensington, W.14
Manna, V. K.	Royal College, Port Louis, Mauritius
McAllister, W. A. C.	Boroughmuir Secondary School, Edinburgh
Milnes, S. D.	Batley Grammar School, Batley
Mitchell, R. G.	Bromley Grammar School, Kent
Nicholson, K. G.	Redditch County High School, Worcester
Nickalls, R. W. D.	Reading School, Reading
Perl, A. L.	St. Mary's College, Middlesbrough
Smith, R. D. S.	Colston's School, Stapleton, Bristol
Sorefan, A. A.	Norwood Technical College, S.E.27
Walsh, R. J.	Becket School, West Bridgford, Nottingham
Way, Beryl, J.	Wallington County Grammar School, Surrey
	Saffron Walden Training College, Essex

Second M.B. Students

Ashman, R. P.	Kelly College, Tavistock and Plymouth College of Technology, Plymouth, Devon
Astbury, N. J.	Rugby, Warwickshire
Barber, N. K.	Ashlyns School, Berkhampstead, Hertfordshire
Barnard, N. J. B.	Hurstpierpoint College, Hassocks, Sussex
Barton, J. S.	Larkfield Grammar Secondary School, Chepstow, Mon., Wales
Bennett, A. J.	Howardian High School for Boys, Cardiff
Brewer, M. E.	Duke's Grammar School, Alnwick, Northumberland
Cembala, J. A.	Corby Grammar School, Northamptonshire
Clark, G. S.	Bradfield College, Reading, Berkshire
Clifford, K. M. A.	Ernest Bailey Grammar School, Matlock, Derbyshire
Cripps, D. F.	Bishop Vesey's Grammar School, Sutton Coldfield, Warwickshire
Davis, W. H.	St. Mary's Grammar School, Sidcup, Kent
Dismorr, Rosalind, M.	St. Joseph's Convent Grammar School, London, S.E.2

Eadie, Elizabeth, J.	St. Mary's Hall, Brighton, Sussex
Ede, Rosemary, M.	Hastings High School for Girls, Hastings, Sussex
Evans, E. J.	Tonbridge School, Tonbridge, Kent.
Fenner, M. T.	King's Norton Grammar School for Boys, Birmingham, 30
Filshie, Jacqueline	Southport High School for Girls, Southport, Lancashire
Fleet, H. M.	Merchant Taylors' School, Northwood, Middlesex
Fleetham, J. A.	Caterham School, Caterham, Surrey
Ford Jones, A. E. A.	Ampleforth College, Yorkshire
Franks, C. R.	Downside School, Near Bath, Somerset
Gartell, P. G.	Reigate Grammar School, Reigate, Surrey
Gatland, D. J.	High Wycombe Royal Grammar School, High Wycombe, Buckinghamshire
Glazebrook, C. W.	Wymondam College, Wymondam, Norfolk
Gillman, D. M.	St. Bart's Grammar School, Newbury, Berkshire
Goodhart, R. A. G.	Rugby School, Warwickshire
Golding, S. J.	Dudley Grammar School, Dudley, Worcester
Goudarzi-Langroudi, H. A.	Hadaf High School, Tehran, Iran
Harrison, I. D.	Brentwood School, Essex
Hewish, P. A. F.	Reed's School, Cobham, Surrey
Holdsworth, B. J.	Southwell Minster Grammar School, Southwell, Nottingham
Hunter, M. C. G.	Abingdon School, Abingdon, Berkshire
James, R. G.	Llandysul Grammar School, Cardiganshire
Jones, B J. M.	Trinity School, Shirley, Croydon, Surrey
Judd, Lucinda, L.	Croydon High School for Girls, Croydon, Surrey.
Kidger, T.	Enfield Grammar School, Enfield, Middlesex
Lamb, C. J.	Maidstone Grammar School, Maidstone, Kent
Lambert, R. J.	Ardingly College, Haywards Heath, Sussex
Leader Cramer, A. H.	University College School, London, N.W.3
Lewis, J. L.	St. Paul's School, West Kensington, London, W.14
Lilwall, N. J.	Medway College of Technology, Chatham, Kent
Mann, C. P.	Mayfield College, Mayfield, Sussex
McNeil, C. H. N.	Forest House, Epsom College, Epsom, Surrey
Macintosh, Angela,	Blackheath High School, London, S.E.3
Macfarlane, Anne, E.	Queen Elizabeth's Girls Grammar School, Mansfield, Nottingham
Milliner, D. H. C.	Canford School, Wimborne, Dorset
Musgrave, R. J.	Sir John Deane's Grammar School, Northwich, Cheshire
Mowschenson, P. M.	Peterhouse, Marandellas, Rhodesia
Nancekievill, M. L.	Rossall School, Fleetwood, Lancashire
O'Keefe, D. B.	Sherborne Boys' School, Sherborne, Dorset
Palin, D. J.	Chetham's Hospital School, Manchester 3
Parry, H. F.	The King's School, Canterbury, Kent.
Pearce, R. J.	Chiswick Grammar School, London, W.4
Pietroni, R. G.	Holland Park School, London, W.8.
Pickup, A. J.	Enfield Grammar School, Enfield, Middlesex
Pinder, N. R.	Stamford School, Stamford, Lincolnshire
Prisk, A. J.	Helston Grammar School, Helston, Cornwall
Rankin, Sheila, C.	East Grinstead County Grammar School, East Grinstead, Surrey St. Lawrence College, Ramsgate, Kent.
Richardson, D. R.	Barnard Castle School, Barnard Castle, Co. Durham
Rogers, A. R.	Tiffin Boys' School, Kingston-upon-Thames, Surrey.
Rosenberg, M. A. J.	Brighton College, Brighton, Sussex
Royston, A. M.	Chislehurst & Sidcup Grammar School for Boys, Sidcup, Kent
Scoble, J. E.	Bishop Gore Grammar School, Swansea, Glamorgan
Scott, G. L.	Merchant Taylor's School, Liverpool, 23
Shaw, M. M.	Rugby School, Rugby, Warwickshire
Shrimpton, Christine, M.	Chesterfield St. Helena School, Chesterfield, Derbyshire
Shutes, J. C. B.	Kent College, Canterbury, Kent
Skinner, P. J.	Chislehurst & Sidcup Grammar School for Boys, Sidcup, Kent
Sorefan, M. S.	Islamic Cultural College, Port Louis, Mauritius
Southwell, P. R.	Woodhouse Grove School, Bradford, Yorkshire
Speirs, Jean, M.	Tigoni Day School, Limuru, Kenya
Stacey, R. K.	Howardian High School for Boys, Cardiff, Wales

Stodell, M. A.	Langley Grammar School, Langley, Bucks
Stubbs, D. F.	Westminster City School, Palace Street, London, S.W.1
Thomas, Dilys, A.	John Bright Grammar School, Llandudno, Wales
Thompson, D.	Bryanston, Blandford Forum, Dorset
Thompson, S. G.	Tonbridge School, Tonbridge, Kent
Tyson, Hazel, M.	Woking County Grammar School for Girls, Woking, Surrey
Walley, Anna, E.	Nantwich and Acton Grammar School Nantwich, Cheshire
Watkin, P. M.	Andover Grammar School, Andover, Hampshire
Way, A. P.	Haileybury and Imperial Service College, Herts.
Wells, S. C.	Brockenhurst Grammar School, Brockenhurst, Hampshire
White, P. M.	Epsom College, Epsom, Surrey
Wood, J. R.	Roundhay School, Leeds, 8
Wood, R.	King Edward's School, Birmingham
	Sherborne School for Girls, Sherborne, Dorset

Clinical Students

Bamford, M. F.	Norwich School, Downing College, Cambridge
de Carteret, J. R.	St. Lawrence College, Ramsgate, Selwyn College, Cambridge.
Fieldman, N. R.	Christs College, London, N.3. Gonville & Caius College, Cambridge.
Forbes, M. J.	Perse School. Clare College, Cambridge.
Howell, N. C. B.	Cheltenham College. Pembroke College, Cambridge.
Kilpatrick, S. M.	Haileybury and Imperial Service College, Herts Queen's College, Cambridge
McNeil, N. I.	Queen Elizabeth Grammar School, Wakefield. Trinity Hall, Cambridge.
Morris, W. J.	Holywell Grammar School. Peterhouse, Cambridge.
Ruddock, J. M.	St. Peter's School, York Corpus Christi College, Cambridge.
Rycroft, R. J. G.	Sherborne School. Clare College, Cambridge.
Samuel-Gibbon, A. G.	Tonbridge School, Kent. St. John's College, Oxford.
Thomas, D. F. M.	Dulwich College, S.E.21
Weatherstone, R. M.	Downing College S.E.21. Corpus Christi College, Cambridge.

October, 1967

DENTAL SCHOOL

First B.D.S Students

Bamford, I.	The Herbert Strutt School, Belper, Derby
	Derby and District College of Technology, Kedleston Road, Derby
Bannerman, Theresa R.	St. Mary's School, St. Leonards on Sea, Sussex
Barker, D. E.	Adams' Grammar School, Wem. Shropshire
Bjornaas, O. M.	Sevangergymnas School, Sevanger, Norway
Dewe Mathews, G. J.	Ampleforth College, Near York
Eikrem, G. I.	Volda off. Landsgymnas Secondary School, Volda, Norway
Forsythe, I. C.	Methodist College, Malone Road, Belfast
Frost, S. B.	St. Probus School, Salisbury.
Hall, G. M.	Canford School, Wimborne, Dorset.
Harrison, J. P. A.	St. Dunstan's College, Catford, London, S.E.6.
Leathers, Valerie, S.	Workington County Grammar School, Cumberland.
McLeod, N. S.	Cottesmore St. Mary's Secondary School, & City of Oxford High School for Boys.
McLeod, R. D.	Ystalyfera Grammar School, Glamorgan.
Newman, G. R.	George Abbot School for Boys, Burpham, Guildford
Niedzwiecka Regina, S.	St. Bernard's Convent, Slough, Bucks.
Nilsen, S. B.	Gjovik gymnas, Gjovik, Norway.
Pickering, D. R.	Westminster School, London, S.W.1.
Reynolds, T. E.	Wirral Grammar School for Boys, Cheshire, & Ellesmere Port Grammar School, E. Port, Cheshire.
Ryan, C. R.	St. Joseph's Academy, Lee Terrace, London, S.E.3.
Standish, J.	William Hulme's Grammar School, Manchester.
Troughton-Smith, S. H.	Selhurst Grammar School.
Wicks, C. R.	Park Grammar School, Marlowe Avenue, Swindon, Wiltshire.
Williams, N. A. K.	Whitgift School, Haling Park, South Croydon.
Winfield, S. A.	Austin Friars School, Carlisle, Cumberland.

DENTAL SCHOOL

October, 1967

Second Year B.D.S. Students

Allen, R. N.	Felsted School, Dunmow, Essex.
Anderson, D. T.	Barrow Grammar School for Boys, Lancashire.

Armstrong, D. B.	Tiffin Boys' School, Kingston-upon-Thames, Surrey
Arnold, D. J.	Duke of Yorks Royal Military School, Dover, Kent.
Bell, K. V.	Poole Grammar School, Gravel Hill, Poole, Dorset.
Bridge, Sophie M.	Hastings High School for Girls, Hastings, Sussex.
Brown, G. R.	Harrogate Grammar School, Harrogate, Yorks.
Brown, Moira	Chislehurst and Sidcup Grammar School for Girls, Sidcup, Kent.
Burn Murdoch, R. A.	The Perse School, Cambridge.
Burt, R. E.	Framlingham College, Suffolk.
Bye, R. M.	Northgate Grammar School, Ispwich, Suffolk
Carmichael, D. M. I.	Huntingdon Grammar School, Huntingdonshire. Kimbolton School, Huntingdonshire.
Casswell, Christine A.	Stamford High School, Stamford, Lincolnshire.
Cooper, I. R.	The Duke of York's Royal Military School, Dover Kent.
Court, R. W. A.	Acland Secondary School, London, N.W.3.
Cranfield, P. J.	Hitchin Grammar School, Hitchin, Hertfordshire.
Dymond, T. J. H.	Newport High School, Newport, Monmouthshire.
Fernandez, Patricia M.	Notre Dame High School, Liverpool.
Ford, B. C.	Lewes County Grammar School for Boys, Lewes, Sussex.
Foster, Anne	Cleveland Grammar School, Redcar, Yorkshire.
Foster, F. J.	Thirsk Grammar and Modern School, Thirsk, Yorkshire.
Glover, D. N.	Huntingdon Grammar School, Kimbolton School, Huntingdonshire.
Gleeson, M. J.	Wimbledon College, Wimbledon, S.W.19.
Gonye, T. J.	King Edward VI Grammar School, Lichfield, Staffordshire.
Goodhand, J. R.	The Grammar School, Barton-upon-Humber, Lincolnshire.
Grazin, Rosalind S.	Allerton High School, Leeds, 17.
Gregg, H. M. C.	The Royal Belfast Academical Institution, Belfast, 1.
Holland, A. A.	Borden Grammar School, Sittingbourne, Kent.
Howlett, Julie A.	Ursuline Convent School, Wimbledon, S.W.20.
Hutchinson, J. S.	The Roan School for Boys, London, S.E.3.
Langley, Diana M.	Wymondham College, Wymondham, Norfolk.
Mayne, Hilary E.	Wimbledon County School for Girls, Wimbledon, S.W.19.
McGlone, J. P. C.	Westcliff High School for Boys, Essex.
McIntyre, M. G. M.	Stowe School, Buckinghamshire.
Massarweh, W.	Terra Sancta College, Amman, Jordan. Braintree College, further Education, Essex.
Merrett, D. J.	Cardiff High School for Boys, Cardiff, South Wales.
Morris, Eleanor V.	Cheltenham Ladies College, Cheltenham, Gloucester.
Munn, D. A. G.	Dunsmore School for Boys, Ashlawn Road, Rugby.
Nicholas, G.	Christ's College, London, N.3.
Novak, M. J.	Eastbourne Grammar School for Boys, Eastbourne, Sussex.
Oakes, Rowena	The Northern Grammar School for Girls, Portsmouth, Hampshire.
Pitt Ford, T. R.	Aldenham School, Elstree, Hertfordshire.
Ross, R. P.	St. John's School, Leatherhead, Surrey.
Samji, M. A.	Nairobi School (ex Prince of Wales School), Nairobi, Kenya.
Sartory, G. F.	Eastbourne College, Eastbourne, Sussex.
Skinner, D. B.	St. Mary's School, Nairobi, Kenya.
Skry, A. A.	Preston Manor County Grammar School, Wembley, Middlesex.
Stevenson-Moore, P.	Nottingham High School, Nottingham.
Stuart, S. D.	Wolstanton Grammar School, Staffordshire
Tennant, J. W.	The Hulme Grammar School, Oldham, Lancs.
Walker, A. P. P.	St. Edward's School, Oxford.
Walker, J. P.	Ackworth School, Pontefract, Yorkshire.
Want, T. J. L.	Reed's School, Cobham, Surrey.
Ward-Davies, A. J.	King Edward VI Grammar School, Lichfield, Staffordshire.
Wee, H. J.	St. Xavier's Institution, Penang, Malaysia. North Western Polytechnic, London, N.W.5.
Wild, G.	Acklam Hall Secondary Grammar School, Yorkshire.
Wright, S. M. P.	Cheltenham College, Cheltenham, Gloucester.
Zabkiewicz, J. R.	Wyggeston Boy's Grammar School, Leicester.

October, 1967

Combined Course,

Guy's Hospital Dental School

Second Year Students

Adams, P. N.	Reigate Grammar School, Reigate, Surrey Guy's Hospital Dental School
Harradine, N. W. T.	Haileybury & Imperial Service College, Windsor, Bershire Guy's Hospital Dental School
Harrison, L. P.	Presentation College, San Fernando, Trinidad Guy's Hospital Dental School

PRIZE

LESLIE HILLMAN PRIZE IN HAEMATOLOGY, 1967

The following awards have been made:—

G. J. Gibson—Medal and Prize

M. Sutton—Certificate.

PUBLICATIONS BY GUY'S MEN

Besterman, E. M. M. and others. Percutaneous catheterization of the axillary vein. *Card. Res.*, 1967, **1**, 297.

Blackburn, G. The thyroid gland. In *Scientific foundations of surgery*, London, Heinemann, 1967.

Blackwell, B. and other. Hypertensive interactions between monoamine oxidase inhibitors and food stuffs. *Brit. J. Pharmacol.*, 1967, **29**, 113.

Blake, G. C., and Forman, G. H. Pre-operative antiseptic preparation of the oral mucous membrane. *Brit. dent. J.*, 1967, **123**, 295.

Blakemore, C. B., and Falconer, M. Long-term effects of anterior temporal lobectomy on certain cognitive functions. *J. neurol, neurosurg. Psychiat.*, 1967, **30**, 364.

Blau, J. N. and Veall, N. Uptake and localization of proteins, Evans blue and carbon black in the normal and pathological thymus of the guinea-pig. *Immunology*, 1967, **12**, 363.

Brock, Lord. Surgery and Lister. *Ann. roy. Coll. Surg.*, 1967, **40**, 355.

Burry, H. C. Quantification of spasticity—preliminary report on a new method. *Ann. phys. Med.*, 1967, **9**, 59.

Campbell, A. M. G. and another. Natural history of Refsum's syndrome in a Gloucester family. *Brit. med. J.*, 1967, iii 777.

Child, J. A., King, J., Newman, T. H., and Waterfield, R. L. Diffraction method for measuring the average sizes and shapes of red blood cells. *Lancet*, 1966, **2**, 891.

Chouverakis, C., Jarrett, R. J., and Keen H. Glucose tolerance, age and circulating insulin. *Lancet*, 1967, **1**, 806.

Coxon, R. V. and another. Effect of intravenously infused saline on the renal clearances of insulin and paraminohippurate in dogs. *Quart. J. exp. Physiol.*, 1967, **52**, 145.

Crabb, H. S. H. and another. Two-dimensional microdensitometry. *Brit. dent. J.*, 1967, **122**, 337.

Cutler, R. Clinical photography for the dental practitioner. *Brit. dent. J.*, 1967, **122**, 350.

Davies, H. and Gazetopoulos, N. Lung function in patients with left-to-right shunts. *Brit. Heart J.*, 1967, **29**, 317.

Deuchar, D. C. Ballistocardiography. *Brit. Heart J.*, 1967, **29**, 285.

Dowling, G. B. Dermatology at Guy's Hospital (1850-1949). *Brit. J. Derm.*, 1967, **79**, 431.

Emslie, R. D. Prevention in peridontal disease. *Internat. dent. J.*, 1967, **17**, 320.

Forgacs, P. Crackles and wheezes. *Lancet*, 1967, ii, 203.

French, E. B. and others. Reflex vasomotor responses in the hands of migranous subjects. *J. Neurol. Neurosurg. Psychiat.*, 1967, **30**, 276.

Fry, J. and another. Acute coronary deaths. J. Coll. gen. Practit., 1967, **14**, 44.

Fry, J. and another. Influenza. *J. Coll. gen. Practit.*, 1967, **8**, 297.

Gunn, A. Electric fire burn. *Brit. med. J.*, 1967, iii, 764.

Harrison, D. F. N. and other. The Ear. In *Scientific foundations of surgery*, London, Heinemann, 1967.

Hawkins, C. F. and another. Dietetics and the vitamins. In *Scientific foundations of Surgery*, London, Heinemann, 1967.

Hoare, R. D. and others. Further causes of hypertrophied tentorial arteries. *Brit. J. Radiol.*, 1967, **40**, 350.

Hunt, J. N., Knox, M. T., and Wan, Beatrice. Slowing of gastric emptying in man by fat soluble and non-fat soluble acids. *J. Physiol.*, 1967, **189**, 66P.

Kelsey Fry, I. and others. Excretion urography. *Brit. J. Radiol.*, 1967, **40**, 561.

Klyhn, K. M. and Gorrill, R. H. Studies on the virulence of hospital strains of *Pseudomonas aeruginosa*. *J. gen. Microbiol.*, 1967, **47**, 227.

Langman, M. J. S. and others. ABO blood groups and secretor status in stomal ulcer. *Gut*, 1967, **8**, 128.

Lehner, T., Cardwell, J. E., and Clarry, E. D. Immunoglobulins in saliva and serum in dental caries. *Lancet*, 1967, **1**, 1294.

Lorber, J. and another. Incidence of spina bifida occulta in parents and controls. *Arch. Dis. Childh.*, 1967, **42**, 171.

Lorber, J. Tuberculous iridocyclitis and sclerokeratitis followed by tuberculous meningitis and miliary tuberculosis in an infant. *Proc. R. Soc. Med.*, 1967, **60**, 894.

Marley, P. B. and Robson, J. M. Passage of ^{22}Na into the uterine lumen of the rat. *J. Physiol.*, 1967, **189**, 67P.

Matthews, E. and others. Training of dental technicians. *Brit. dent. J.*, 1967, **123**, 182.

McHardy-Young, S., Harris, P. W. R., Lessof, M. H., and Lane, C. Single dose dexamethasone suppression test for Cushing's syndrome. *Brit. med. J.*, 1967, **2**, 740.

Meadow, S. R. Mongoloid features with normal chromosomes-dysplasia epiphysialis punctata. *Proc. R. Soc. Med.*, 1967, **60**, 895.

Milstein, B. B. Acute circulatory arrest. *Brit. J. Surg.*, 1967, **54**, 471.

Naylor, M. N. and Emslie, R. D. Clinical testing of stannous fluoride and sodium monogluophosphate dentifrices in London school children. *Brit. dent. J.*, 1967, **123**, 17.

Northfield, D. W. C. and another. Pupertas praecox due to hypothalmis hamartoma: report of two cases surviving surgical removal of the tumour. *J. Neurol., Neurolsurg. Psychiat.*, 1967, **30**, 166.

Parks, A. G. Post-anal perineorrhaphy for rectal prolapse. *Proc. R. Soc. Med.*, 1967, **60**, 920.

Pike, Juliet and other. Cause of death in children with meningomyelecele or hydrocephalus. *Arch. Dis. Childh.*, 1967, **42**, 163.

Prieskel, H. Prefabricated attachments for complete overlay dentures. *Brit. dent. J.*, 1967, **123**, 161.

Proctor, E. Circulatory support by pump-oxygenator in experimental ventricular fibrillation and acute left heart failure induced by coronary artery ligation. *Cardiovasc. Res.*, 1967, **1**, 189.

Proctor, E. Supportive perfusion. *Brit. J. Surg.*, 1967, **54**, 474.

Proctor, E. Supportive perfusion in the treatment of pulmonary embolism. *Ann. roy. Coll. Surg. Eng.*, 1967, **41**, 302.

Robinson, A. D. The experimental determination of the force produced by expansion of dental amalgam. *Brit. dent. J.*, 1967, **122**, 377.

Ross, D. N. Monitoring requirements during cardiac surgery and in the post-operative period. *Proc. R. Soc. Med.*, 1967, **60**, 359.

Spicer, C. Computers. *Med. Wrld.* 1967, **105**. 15.

Tulley, W. J. Prevention in orthodontics within the scope of the school programme. *Internat. dent. J.*, 1967, **17**, 368.

PERSONAL

GUY'S GRADUATE, 1955, requires assistant with definite view for single-handed expanding practice in rapidly-growing area ten miles from Adelaide. Interest in obstetrics or anaesthetics an advantage. For further information apply: *David Gill*, M.B., B.S., D.C.H., Box 55, Tea Tree Gully, Southern Australia 5091, or Jimmy Goodliffe, Appointments Bureau, Guy's Hospital.

WANTED—conservation kit. Please contact E. P. Brown by note in letter rack, East Wing.

CHANGE OF ADDRESS

Dr. and Mrs. Michael F. H. Bush, 5, Days Green, Capel St. Mary, Ipswich, Suffolk. Tel. Great Wenham 554

R. S. Cook, 9, Luton Close, Eastbourne, Sussex.

Dr. and Mrs. Morton Figgis, Toad Hall, Swilland, Ipswich, Suffolk. Tel: Witnesham 349

Dr. R. V. H. Goulder (from November 1st, 1967), The Cottage, Victoria Road, Diss, Norfolk.

Dr. and Mrs. Clifford Harley, "Slopes", Lunghurst Road, Woldingham, Surrey, CR3 7HF. Tel. 01-905 3294.

Dr. R. A. Johnson, Grainsby, South Ferriby, Barton-on-Humber, Lincs.

Surgern Lieutenant (D) and Mrs. D. R. A. Lloyd-Edwards to Middledown House, Stoke Fleming, Dartmouth, Devon.

Dr. and Mrs. J. R. F. Popplewell, 45, Charles Close, Wroxham, Norwich NOR 032. Tel: Wroxham 2466

Miss Jenifer M. Reckitt, Yew Tree Cottage, Stoke Fleming Nr. Dartmouth, Devon.

Mr. W. A. A. Renner, The Dental Surgery, 57, Warwick Road, Beaconsfield, Bucks. Tel: Beaconsfield 2058

Dr. T. M. Robb, Pinegarth, Windbourne Close Kilmorie, Torquay, Devon.

Dr. J. Warner (for one year), 16, Mona Road, Kingston 6, Jamaica, West Indies.

BIRTHS

CLARK—On October 2nd, at Emanuel Hospital, Portland, Oregon, U.S.A, to Margaret (née Stewart), wife of Dr. Roy Clark, a son, Timothy Stewart, a brother for Graham.

GREENWOOD—On 29th September, 1967, at trail, British Columbia, to Joan (née Keizer) and Noel Greenwood, a son, Alexander Bennell, a brother for Gillian, Joanna and Penelope.

LLOYD-EDWARDS—On 6th May, 1967, at B.M.H. Singapore to Jennie and Adrian Lloyd-Edwards, a daughter Gwen Elizabeth. Sister for Sian and Ceri.

MARRIAGE

LEWIN—BANBURY—On 23rd September, 1967, at St. Margaret's, Kings Lynn, Dr. Richard Lewin, son of Mr. and Mrs. J. Lewin, to Mrs. Elspeth Banbury, daughter of Mr. and Mrs. W. F. Page.

WHITE—COOK—Miss Ella Kathleen White to Reginald S. Cook L.D.S. at Eastbourne.

DEATHS

BURCH—On 14th October, 1967, H. J. Burch, L.D.S., R.C.S., (England), Vermont, Stow Road, Purleigh, Essex.

COURT—Constance Margaret Wyatt Court, A.R.R.C., on 5th September, 1967. Trained at Guy's Hospital School of Nursing, 1924-1927. Subsequently Assistant Home Sister, Assistant Night Sister, and Sister in Charge of *Out-Patients' Department*.

CROOK—On 7th October, 1967, aged 74, Frances William Crook, L.D.S. Eng., M.R.C.S. L.R.C.P. of 16, Michanbury Lane, Bitterne Park, Southampton.

SCHOFIELD—On 9th September, 1967, at Mount Pleasant Cottage, Ireton Wood, Nr. Idridgehay, Derbyshire. James Barlow Schofield, aged 62 years.

We would like to remind our readers that all copy for inclusion in the Gazette must be received eight days before publication date.

Personal notices and Birth, Marriage, and Change of Address notices must be pre-paid.

Personal notices one shilling per word (minimum £1. 1s. 0d.)
Birth, Marriage, Death, and Change of Address notices are without charge to subscribers.

Non-subscribers will pay £1. 1s. 0d. (pre-paid) for all notices other than Personal or Death.

GUY'S HOSPITAL GAZETTE

EDITORS D. S. ROBINS and C. B. BROWN
SPORTS CORRESPONDENT J. G. PAYNE
NURSING CORRESPONDENT E. A. MALPAS

FORTNIGHTLY TWO SHILLINGS VOLUME 81 NUMBER 2069

The opinions expressed in these columns are solely those of their authors and are not to be taken as the views of the Hospital as a whole.

PASSIM

From A to B, or how I won a medal

As was inevitable, the College has not yet been completely demolished. It lingers on; the demolition continues at a rate which can probably only be accounted for by the odd brick or two being removed in the dead of the night by late-coming souvenir seekers. Not even November 5th revellers could hasten the final flattening, wherein lies yet another moral. Or is it that almost everyone has been scared off by recent mention in *Gazette* correspondence of the building's connection with the dreaded mycobacterium?

What we are blessed with at the moment, however, is the exciting obstacle race overland from the entrance of New Guy's House to Hunt's House. Ready? Stroll quietly, dodging incoming cars and ambulances made invisible by November fog or foggy drizzle, down towards the College. Neatly sidestep a falling brick from that edifice but trip, unfortunately, in one of the furrows that pass across the road. Naturally, you avoid concussing yourself against a sign which considerately advises you to avoid danger overhead. Turn the corner and duck under the swinging business end of the mechanical trench (another) digger, carefully twisting to the left simultaneously to avoid being struck by the Dixieland Express laundry train (and mind that danger overhead). But breathe again, fellow traveller, for you now have ten yards of clear passage. But no more, as you all but rupture that lateral ankle ligament trying to maintain a vertical position as you pass over the muddy, slippery, encrusted, spewed-up earth from trench No. 2 But do not worry about falling, for many a helping hand may be available from the perpetual mass of orderlies, porters, etc., blocking the road, waiting about just in front of you for an average half-hour before they stamp their clocking-out cards. But then, mind in what direction you are released, for as you are about to crawl up the moat-bridge over The Trench—the *original*—you have only nine inches between the railing and the onrushing hospital van/lorry/flower delivery van driven by neo-flower girl/orange Lotus Elan ex-Nuffield House / pharmacy trolley / fourteen-minutes-past laundry express. Stiffen the upper lip, brush the tyre marks off your

shoes and attempt to walk on, or rather hop as you enter upon that musical keyboard known as the temporary roadway. Jump, delicately mind you, over the succession of compressed air pipes and when you land make sure it is on a board that is still or is sinking itself under the weight of a pair of Michelins beside you. Fear not, however, for you are passing the Physical Medicine Department on your right (or is it too shelled-out by now?) where cervical traction is readily available if you happen to come down on a board that is rising. Place your next steps carefully, for the pigeons above by rota are expressing their disdain upon this somewhat unaesthetic part of the course. You are nearly home now, so take heart. Continue *en glissade* onto the pocked (no prizes for naming causal agent) old roadway, protecting eye and ear from the shrapnel and merciless rattling both produced by the compressed air drill eating its merry way into the floor of Ruth Ward. But you surely are not going to clutch the railing available to regain balance! Even if blinded and deafened, you should be able to sense the imminent, passionate embrace between that railing and, yes, there it comes, the seventeen-minutes-past. For remember, to get to the Hand Clinic you will have to go all the way back to the start.

Well done, you've made it. There was nothing to it, was there? Especially knowing that there was a hospital nearby.

Somewhere.

Verbal Fireworks

On the Continent, fireworks are an almost inevitable accompaniment to any festivity—a Saint's day, birthday, wedding or public holiday. In England they are reserved for the celebration of the failure of an otherwise obscure Roman Catholic soldier's attempt to blow up the Houses of Parliament.

Perhaps it is typical of the English character that we have perpetuated the memory of this (now) insignificant occasion of national unrest, rather than, for example, the crowning of Queen Elizabeth I, the defeat of the Armada, or Trafalgar Day.

Why has the burning of the effigy of Guy Fawkes so caught the imagination of the nation that it is still—three hundred years later—the most widespread national, unofficial, festival? What can the Anthropologists and Sociologists tell us about the strange "motivational factors" that make us preserve this strange festival of ritual killing? Would Dr. Morris explain that we were all trying to singe off what remains of our vanishing hair?

With the introduction to Guy's of a new society—Outlook—we may soon be given the answers to this, and other more serious questions about human behaviour. Outlook is the Guy's Sociological Society.

It has been formed to encourage discussion on the structure and behaviour of societies, with special reference to Britain, and the largeness of the subject should enable the Society to provide interesting topics for discussion for a very long time.

Two well-attended meetings have been held up to this time; the most exciting aspect of which has been the eagerness shown by the members to reply to the visiting speakers and to put forward their own views.

Since the demise of the Quodlibet Society, the Debating Society has been the only forum for non-medical discussion at Guy's, and the arrival of this new, and more informal medium should be warmly welcomed.

We draw our readers' attention to the fact that reprints of the articles in our series of Current Medico-Legal Problems will shortly be available, either singly or as a complete booklet. Price will be dependent upon demand, but should not be more than a few shillings per booklet. Orders should be sent to the Manager.

College Paintings

It will be of interest to those who remember the paintings by G. Earle Wikham that were in the College Smoking Room (T.V. room to later generations) to know that the largest of the three—showing Thomas Guy watching death being driven from the Hospital by various nurses, doctors, gardeners, a cat and a rugby scrum—has now been hung, or rather supported, in the reading room in the East Wing. This rather lighter room shows off the picture to great advantage.

It is hoped to find homes for the two smaller pictures in the near future.

For there it is.

GUY'S DIARY

NOVEMBER

		EXHIBITION: The Suprarenals. In the Gordon Museum.
13th	M.	Clinical Lecture. Dr. BAKER. "Tachycardia."
14th	Tu.	Clinical Lecture. Dr. MACKENZIE. "The Maintenance and Failure of the Cerebral Circulation."
16th	Th.	Clinical Lecture. Dr. HARDWICK. "Diverticula of the Intestinal Tract."
17th	F.	Clinical Lecture. Dr. KAUNTZE. "The Electrocardiogram."
20th	M.	Clinical Lecture. Dr. STAFFORD-CLARK. "Bloody Confusion: or Physic to the Dogs."
21st	Tu.	Clinical Lecture. Prof. Sir HEDLEY ATKINS. "Malignant Disease of Bones."
23rd	Th.	Clinical Lecture. Dr. JOINER. "Diseases of the Arteries (1)."
24th	F.	Clinical Lecture. Dr. G. E. W. WOLSTENHOLME. (Director Ciba Foundation and Hon. Secretary Royal Society of Medicine). "A Health Service for the World."

We offer our congratulations to Dr. J. R. Batchelor on his appointment an Honorary Research Professorship in the Royal College of Surgeons in respect of his appointment as Director of the McIndoc Memorial Research Unit, Queen Victoria Hospital, East Grinstead.

FELIX TOMLYN

His many friends and colleagues will mourn the loss of Felix Tomlyn.

Son of a dental surgeon, he was educated at Malvern and entered Guy's in 1923. He qualified L.D.S. in 1928, and after obtaining a house surgeon appointment, took over his father's practice in Sevenoaks.

A man of great artistic talent, he would give much pleasure to his friends with his sketches of the contemporary dental consultants and tutors, usually with a satirical note or rhyme, very true to life but never spiteful. His pastels of the surrounding beautiful country, of his native Kent, were delightful.

His interests were widespread and varied. Apart from his great love of art—beagling, amateur dramatics (for which he would paint all the scenery), town planning and writing were just a few examples of his versatility.

He joined the R.A.D.C. in the early part of the war but was invalided out on medical grounds. Always interested in children, Tomlyn took up school dentistry under the Kent County Council, and his handling of childen, at which he excelled, was most effective in eradicating the fears of the dental chair.

His artistic temperament came into play in his profession and was evidenced by beautiful conservative work.

Never of robust health, he developed heart trouble, but this did not prevent him from carrying on his duties as cheerfully and efficiently as before.

He retired from school dentistry about two years ago and devoted his time to art and writing.

A staunch friend and one of "nature's gentlemen" is the epitaph which most truly fits Felix Tomlyn.

Our sympathy goes out to his wife, Peggy, who sustained him throughout his long disability.

G. E. KING-TURNER

KATHLEEN A. SHACKLE

Kathleen A. Shackle died on Sunday, October 22nd, after a short illness. As Kathleen Burton, she entered Guy's in 1917. She had already completed children's training at Pendlebury. Appointed Night Sister in August, 1921, and later in the year to the Preliminary School until 1923, when she moved to Esther (then women's medical ward), until 1925. On return to Guy's, January 6th, 1927, she was Sister of the Children's ward, the small, busy ward at the end of the Park, where Nuffield House now stands.

She enjoyed working with Dr. Cameron. She loved the children. Fond of music, a keen tennis player, for some years she was swimming representative for the Nurses' League. In 1930 she married John W. Shackle, whom she had known as house physician.

Kathleen Shackle's activities for Guy's continued as energetic Hon. Treasurer of the Guy's Hospital Nurses' League 1939-1963. In her first report as Hon. Secretary, Miss A. M. Johnson reported at the annual meeting of the League on May 8th, 1963, the resignation of Mrs. Shackle as Hon. Treasurer. Then—"the President, on behalf of the Council, expressed great regret that Mrs. Shackle was retiring as Hon. Treasurer after 24 years. She thanked Mrs. Shackle for her untiring work and interest in the affairs of the League, and on behalf of the members presented her with a small gift as a token of appreciation."

Kathleen's kindness and thoughtfulness for others (and recently, her joy in three young grandchildren), will long be remembered by her colleagues and friends. Our sympathy goes to her husband, Dr. John Shackle, her son, David, and her daughter-in-law, Rosalind, who was a Guy's Sister.

CURRENT MEDICO-LEGAL PROBLEMS

5. THE MOMENT OF DEATH

"Is he then dead?
What, dead at last, quite, quite for ever dead!"
William Congreve—The Mourning Bride.

Death, called *mors* for it is bitter, is the one inevitable event in everyone's life. It is defined (O.E.D.) curiously accurately in the context that is now of so much more interest to doctors and the law as "the *final* cessation of the vital functions". It is, indeed, the moment at which life is irrevocable that is final. "Over them triumphant Death his dart shook; but delayed to strike", Milton wrote. When, indeed, is the moment of strike?

For centuries, the cessation of heart-beat, of respiration, of reflexes, of reaction to stimuli so vividly portrayed by the novelist and playwright—so obviously the end—have been the criterial of death: the dropped jaw, the glassy stare, the mirror that lies unchanged before the mouth, have all justified the drawing of a sheet over the face, the sign of the cross, the undertaker and interment. Though the law of most countries may demand it, the services of a doctor would seem to be superfluous before final commitment.

But the fear of premature pronouncement of death has always worried man. Wiertz, the Brussels artist, painted a macabre reminder of the possibility when he portrayed the cadaveric hand of a victim of typhoid "mort-certifie par nous docteurs" raising *from inside* the lid of a coffin to reveal a hollow face peering out on to the departed world. Is it possible? Does it ever happen? The answer is, undeniably, yes.

Reprinted by courtesy of "Abbotempo", published by Abbott Laboratories.

In 1957 a 78-year-old solicitor's widow, found apparently dead with suicide notes and an empty box of sleeping tablets by her side, was removed by undertakers to a public mortuary where, 6 hours later, a young police officer attending to identify, found her to be breathing; and in 1956 a Melbourne woman sat up and spoke to the constable deputed to search the body in the mortuary. She later walked out of the hospital—and survived.

Hardy, the novelist, was said to have been retrieved by the midwife who arrived to find the newly-born infant had been laid aside as dead.

Infants struggling weakly to survive their birth, persons gravely shocked, so ill that life barely flickers, with animation suspended by electric shock, in cataleptic or hypnotic—or drugged—states may all appear to be dead, and it may be exceedingly difficult for a doctor to detect, even by stethoscope, the flicker of life that may be present. Medical students are warned of the grave danger of the slightest carelessness about examination for the signs of death, but seldom have much experience of the "moment of death" in their hospital training—indeed may never have seen anyone die before they are qualified to practise.

And now the remarkable advances in methods of resuscitation, the increased effectiveness of analeptic and tensive drugs, and more, the technical procedures by which surgeon and anaesthetist can shrink a man's metabolic needs by hyporthermia, maintain a heart's vitality by coronorary perfusion or restore its rhythm by defibullation or pace-maker, and sustain a respiratory excursion by pulmoflator, have created new problems in deciding the moment of death.

Moral Issues

It is possible to maintain tissues in a living state by artificial means for purposes of treatment or in the hope of improvement which will allow surgery to be undertaken, even though the body is no longer capable of the mechanisms of survival if left to itself. When, thus, is one to pronounce death? When the heart first ceases to beat after collapse or on electric or vagal inhibitory shock? Or when, after temporary revival by artificial means, all hope of recovery of consciousness or spontaneous survival as a whole being capable of survival if left without artificial sustenance. The newspapers frequently "feature" those who "died" on the operating table and recover: but what of those who "die" and whose tissues are being kept alive by artificial means. Are those in charge to decide when to withdraw, when to allow the state of death to continue until the cells also die? Is this a moral issue? Can a surgeon or anaesthetist decide that the future is without hope? Has a doctor who feels the weight of his Hippocratic Oath the moral right to cease combative treatment, dialysis for a chronic nephritic, cortisone, the pace-maker, a pulmoflator or other breathing device for the polio victim, sustenance for the brain that is irreparably crushed in a car accident?

Professor Calne, of Cambridge, writes in the British Medical Bulletin of 1965, "It is common for a patient with cardiac arrest occurring in hospital to have the heart beat restored by cardiac massage. If there is evidence of severe brain damage, *then it is customary not to attempt further cardiac massage should another cardiac arrest occur:* and again, but more firmly, "If there is no evidence after a given period of time of brain recovery, it is customary to disconnect the machine *and allow the patient to die.*"

Physical Signs of Death

How long should one wait before pronouncing death and what signs should the doctor continue to search for before relinquishing his care of his patient? Pulse? Often too faint to be sure of heart beat. Often most difficult to detect if very weak, may be only intermittent or suspended. Breathing? Far too uncertain. Red cells rolling to a stop or forming rouleaux in the retinal vessels? Very difficult to see unless one is skilled with the ophthalmoscope. Pupil reaction? Fixed by fear, drugs, injury. Reflexes? Can be elicited long after death, as at autopsy over an hour after judicial execution. ECG or EEG? But ordinary doctors don't carry these complicated machines with them.

It is obviously necessary to go on listening with a stethoscope for some minutes, but even silence does not mean irretrievable death. In hypothermia or profound drug comas, the heart beat may remain so thin as to be undetectable for several hours though life is present. Hospitalisation, the resuscitation unit, and electrical detectors that will note the merest flicker of life are, in cases of real doubt, the only safe recourse. In the Massachusetts General Hospital at Boston, a still EEG is demanded—partly to satisfy the law and a litigious public urged on by sensational journalism.

> This can, of course, be carried too far. During the 1939-45 war, I examined the body of a Chinese who had hanged himself in a bombed-out house in East London's Chinatown. He had been hanging dead so long that his body had become dried, covered in parts with moulds, mummified in fingers and toes. But first aid and ambulance men, and a doctor who was called to the scene, carried on artificial respiration and continued this until, on arrival at hospital, an older and more practical doctor pointed out that the man must have been dead at least 5 or 6 weeks !
>
> In another case, a woman was found in a house unconscious on her bed, still but—the doctor thought when called—possibly just alive. Artificial respiration and oxygen were given as the ambulance rushed her to hospital. It was left to the casualty officer, a very young but practical doctor, to point out that it was not much good continuing such measures unless they removed the stocking which was tied tightly round the victim's neck. She had been strangled !

Practical Problems

Rapid advances in surgery have introduced the possibility of grafting tissues from the freshly dead into those who sorely need "new parts"—heart valves nerves, tendon, corneal membrane for the blinded, kidneys,—maybe soon whole heart-lung preparations. The eager surgeon, faced with a natural shortage of volunteer (live) donors, is now faced, with the problem of getting suitable tissues or whole organs from those who have just died—before degenerative changes can set in. This needs planning in great detail : donor and recipient must be near each other, preferably in the same building for celerity of transfer. The surgeon and his team must be ready as the time of death draws near; relatives may have to be contacted and persuaded to approve; the coroner (in cases of death from injury or unnatural causes) must give approval—and can only assume authority when death has taken place; lawyers may intervene with their own special problems. All this consumes time—vital time, and makes the project the more uncertain of success.

Above all, the fact of death must remain in no doubt: the moment of death is the starting pistol for a race to save life. To anticipate death by a moment and operate for the removal of tissue or an organ, loss of which would not benefit the donor, is to commit an assault. Indeed, it might—and has been said to—precipitate death in one who could conceivably have survived.

> In a case in which a man of 32 had been seriously injured in a criminal assault in Newcastle in 1963, the approval of the wife (and the coroner) was sought—and obtained—for removal of a kidney at death. The charge of manslaughter which later ensued, failed as a result of this, counsel arguing successfully that the accused would not be standing trial for the killing had it not been for the removal of the kidney. Final, irretrievable death had not, he said, occurred when the operation was undertaken: the man had "stopped breathing" 14 hours after admission, and had been kept alive on a respirator for a further 24 hours—*when the machine was stopped and the kidney removed.* Was life being maintained only for this purpose? Could it have been preserved longer?

When did death occur? When breathing first stopped, or when the maintenance of a live state was abandoned—the surgical team then being ready? Removal of the kidney was unlawful since, if life was being maintained, the procedure was of no therapeutic advantage to him—indeed, the contrary. The Human Tissues Act 1961, does not help, since it is concerned with the removal and preservation or use of tissues from the body of one on whom a doctor has satisfied himself "by personal examination of the body . . . that life is extinct".

Professor Elliot's views on this were that without the man's personal approval (which he is in no position to give), the act is both a crime (malicious wounding) and a tort (battery) for which damages

may be sought. By removing the means of continuing to sustain life, the doctor might be said to be guilty of homicide—at least technically. Euthanasia is not lawful. And if the doctors precipitated death then, at law, accused could not be held responsible for it. The law calls this a *novus actus interveniens* and it interrupts the chain of events for which an assailant might normally be held responsible.

The law is, perhaps, an ass, as Dickens averred, but it is the guardian of man's rights. What of survival in estate duty or insurance problems? The timing of death in such cases can be of the greatest financial importance to the Commissioner of Inland Revenue or to legatees. What of joint tenancies, or a beneficiary with a contingent interest who might need to reach the age of say 21? What of those who need to survive five years after parting with their wealth to avoid the clutching hands of the tax man? These legal problems have acquired new interest as a result of the technical skills doctors have acquired in the art of prolonging life.

The Future

In Copenhagen in 1966, an International Conference agreed to put forward for discussion a proposal which I felt might avoid some of the major difficulties which tissue and organ transplantation have raised. It read : That no unlawful act shall have taken place when:—

1. *after death,* and
2. *whilst tissues are being maintained* (artificially) in a *"living state"*;
3. *material is removed for the purposes of medical or surgical treatment.*

This was approved as a working basis on the understanding that there *was* a difference in being alive (in the sense of being able to survive, breathe and maintain a circulation without artificial help), and having one's body, organs and tissues, kept alive by artificial means : this latter state is akin to the preservation of graft tissues. The use of the simple word "death" was deliberate : it meant "death" as doctors and nurses have recognised it for centuries—the Greek somatic or bodily death, not cellular or biochemical or enzymatic but plain, physical death——what Congreve called "dead, at last, quite, quite for ever dead".

"A man," Browning wrote, "Can have but one life and one death" if *it is* death. And generally, when sufficient time and care have been taken to ensure that life is extinct, it is : it is when examination is conducted in unsatisfactory conditions, in a noisy street or with machinery pounding nearby, with wailing relatives giving vent to their sorrow, or when in doubtful suspension by life's thread, a decision is made without resort to resuscitative measures, that mistakes

are made. If the body recovered from under a lorry, dragged away from the electric current or collapsed on the bus does not respond to continued artificial resuscitation, lies still, grows cold and stiff, there can be no doubt. Death is certified when skilled restorative measures are finally abandoned : it may well have occurred in the first instance.

Doctors must not go about this in fear of abuse or litigation. The practice of medicine is full of responsibilities which must be grasped like nettles, firmly. No doctor can expect to remain free from criticism, and the important thing is to foresee the possibility and plan to meet it, or disaster may follow.

> In 1963, the Central Medical Board of Sweden declared a doctor guilty of (a) omitting treatment (which was keeping an old lady of 80 with a cerebral haemorrhage alive)—intravenous therapy was withdrawn, and (b) asking the relatives for consent —which they gave. He had, it emerged, asked similar permission in another case, saying he had it on a previous occasion. This time the nearest relative, a son, asked for help as "he was afraid the doctors were going to kill his mother". The problem was whether the patients were dying, for if they were, to continue the treatment that was doing them no good was useless : to discontinue it could not be called "killing".

This is a simple restatement of the Hippocratic Oath : "I will follow that system of regimen which, according to my ability and judgment, I consider for the benefit of my patients." To permit life that is ebbing to come as quietly and painlessly to its close as a doctor can is "to abstain" (as the Oath goes on) "from whatever is deleterious and mischievous". So when Professor Calne writes (*vide supra*) that "it is customary to disconnect the machine and allow the patients to die", it is in no sense contrary to humanity or a doctor's moral code.

The moment of death may have important legal and medical issues, but the bitter fact—what Oscar Wilde's Reading Gaol doctor called a "scientific fact", is seldom in dispute. When it is, a little common-sense and a clear mind will resolve the issue. This, it should be added in postscript, will not stop the lawyers arguing—as a contemporary cartoon showed—nor can any definition of death dispel the doubts that some may voice :—

> "E's all 'ot sand an' ginger when alive
> An e's generally shammin' when e's dead !"
>
> (*Rudyard Kipling*)

KEITH SIMPSON

WILLS LIBRARY ANTIQUITIES

9. BENJAMIN MARTEN AND TUBERCULOSIS

by William Hill

Benjamin Marten is a comparatively unknown figure in medical history, yet he came nearer to the truth of the causation of tuberculosis than any other man for more than 150 years.

Nothing of his life is known except that he lived in Theobald's Road, "near Red Lyon Square, in Holbourn". He wrote one book which is now a rarity yet he postulated the existence of the tubercle bacillus 162 years before Koch's discovery. His book, *A new theory of consumptions; more especially of a phthisis or consumption of the lungs,* was published in 1720 and a second edition was issued in 1722. Of his own views he said :

> "As to the theory advanced in the second chapter, I am sensible much more might have been urged in favour of it, than the reader will find; however, I think I have said enough to evince the reasonableness and probability of my conjectures . . . and to afford sufficient hints to some abler hand, whose abilities are more equal to the task, to carry the theory much farther than I have done, and, it may be, bring it to absolute demonstration, in an extensive degree."

Antony van Leeuwenhoek made his first announcement of his "little animals" in 1673 and in 1681 and 1683 observed bacteria in the mouth and spirochetes and protozoa in faeces. However, he made no attempt to apply these discoveries to the causation of disease. Marten appears to have been one, if not the first, to do this. In his second chapter he writes :

> "The Original and Essential Cause, then, which some content themselves to call a vicious Disposition of the Juices, others a salt Acrimony, others a strange Ferment, others a malignant Humour (all which seem to me dark and unintelligible) may possible be some certain Species of *Animacula* or wonderfully minute living Creatures, that, by their peculiar Shape, or disagreeable Parts, are inimicable to our Nature; but, however, capable of subsisting in our Juices and Vessels, and which being drove to the lungs by the Circulation of the Blood, or else generated there from their proper *Ova* or Eggs, with which the Juices may abound, or which possibly being carried about by the Air,

may be immediately convey'd to the Lungs by that we draw in, and being there deposited, as in a proper *Nidus*, or Nest, and being produced into Life, coming to Perfection, or increasing in Bigness, may, by their spontaneous Motion, and injurious Parts, stimulating, and perhaps wounding or gnawing the tender Vessels of the Lungs, cause all the Disorders that have been mentioned, *viz.* a more than ordinary Afflux of Humours upon the Part, Obstruction inflammation, Exulceration, and all the other *Phenomena* and deplorable Symptoms of this Disease."

He goes on to postulate that various species of *Animalcula* cause different diseases :

"Thus one Species of *Animalcula*, by means of their wonderful Smallness and injurious Parts, may instantly offend the Brain and Nerves, and cause Apoplexies and sudden Death, whilst other Species may produce the Plague, Pestilential or Malignant Fevers, Small-Pox, etc., and others again Chronick Diseases, such as Hypochondriack Melancholly, Vapours, Scurvy, Gout, Rheumatism, Evil, Leprosy, Consumption, etc."

and devotes several pages to epidemiology, discussing the spread of plague and smallpox. Of plague he says :

"If it be once allow'd that the Plague, Pestilential and other *Epidemick* Diseases are caused, and carried on by very minute volatile insects . . . we may then easily conceive how they are conveyed to and from distant countries or climates, *viz.* by such Volatile *Animalcula* or their *Ova*, or Eggs, being deposited in the Bodies, or Cloaths, or goods of Travellers, *etc.*"

He postulated that venereal disease was caused in the same way although, in common with the generally held views of the age, he considered that gonorrhoea was a milder form of syphilis.

Of the spread of infection he says :

"It seems much more probable, that the minute animals or their seed, which we have suppos'd to be the essential cause of a *Phthisis* or Consumption of the Lungs, are for the most part either convey'd from parents to their offspring Hereditarily, or communicated immediately from distempered Persons to sound Ones who are very conversant with them ; . . .

"It may be therefore very likely, that by an habitual lying in the same Bed with a Consumptive Patient, constantly Eating and Drinking with him, or by very frequently conversing so nearly, as to draw in part of the Breath he emits from his Lungs, a Consumption may be caught by a sound person; for it may be reasonable to suppose that if the Blood and Juices of such distemper'd People, be charged with vast quantities of *Animalcula* as I have conjectur'd, then their profuse Sweats, and their Breath also, may be likewise charg'd with them or their *Ova* or Eggs, which by that means may possibly be convey'd into the Bodies of those who lie, or are most conversant with them."

Marten never knew how near he was to the truth. The book was forgotten, no contemporary appears to have quoted it and it was left to Koch many years later to be "the abler hand" which brought his theory "to absolute demonstration, in an extensive degree".

THOUGHTS AND FACTS ON GENERAL PRACTICE — A CAREER —

by

D. W. MAYMAN

Whenever I read an article written by a GP or his wife, about his work, it always appears to me that he works not less than 36 hours a day, and his week contains not less than 10 days. his children do not know him, he is always late for or disturbed at meals for some acute emergency, is out on calls most of the night and is, of course, in an exhausted condition. By comparison his patients may feel quite fit when they see him, but can hardly feel reassured.

Clearly the work this doctor is doing requires a group, or he is, and many are, quite incapable of organising his practice and his life. Such a picture can hardly encourage recruitment to general practice, and it is the object of this article to enquire what is it that medical students do not like about practice and what would they like to see in it. I hope that comment may be stimulated and even if it is not that will also be significant.

I understand that only some 30 per cent of students are thinking of entering practice, whereas a generation ago we were told that 80 per cent of us would find ourselves in general practice. Certainly none of us expected to practise hospital medicine as GPs and we knew that the two were quite different, but this would not now appear to be the case.

The main drawbacks to recruitment fall under three headings:—

(1) **Professional.**

The criticism here is that there is not enough job satisfaction and that the conditions and place of work do not allow satisfactory professional work to be done.

I agree that surgeries need to be improved and this might best be done by the local authority building clinics for GPs to work in and to rent, all ancillary help being provided. A reasonable rent can now be recovered from the Government under the new system of pay, and however much doctors may sink into their surgeries, they cannot compete with local authority accommodation. There is a poor return on capital spent in this way by the GP and he would find it difficult to get the incoming young doctor to pay him for his investment. First-class rented accommodation is the answer, I believe, and better still where there is a new District Hospital being built, then build the clinic there.

If something like this is not done, can we expect to attract young doctors into general practice?

(2) **Pay and Conditions in the N.H.S.**

A long and somewhat sad picture is presented over negotiations about pay. After some seventeen years, GPs began to realise that the pool system of pay meant a limited amount of money for an unlimited amount of work. A roar of dissatisfaction was heard and the Doctors' Charter was negotiated with the Review Body and the Government. I believe the Review Body was most influenced in granting a rise in pay by the fall in the number of doctors in general practice and the rise in emigration.

The new pay system is an improvement, I believe, and contains within it elements of salary and item of service. It is a complicated system and thus unsatisfactory but we shall need some two years to see how it works out, and not seventeen years as with the pool system, I hope.

Conditions of service have been with us almost unchanged since 1948. No industry would agree to such a long, unchanging set of conditions, and neither should we. The B.M.A. is now negotiating with the Government on conditions of service and let us hope that there will be changes in these somewhat harsh rules, not now in keeping with modern conditions. In my view the terms of service can never be considered founded on equity when only one side can make a complaint.

(3) **Choice of Career.**

There is now a great increase in choice of career and in this I include emigration, a choice not open to those qualifying a generation ago. The specialities have increased in number, also the number employed in these specialities, even if this is not much consolation to the frustrated Registrar of today. More doctors are employed in Industry, Public Health, and the Forces. It is thus less than ever necessary to look to general practice as a career.

The frustrations and dissatisfactions expressed by GPs in the N.H.S. are not confined to this country alone and appear to be general throughout Western Europe, and this includes loss of status. Much Medicine previously done by GPs has departed into hospital and quite rightly, so perhaps the GP should follow it. I believe that General Practice can still offer a satisfying career and your work is very much what you make of it yourself. General Practictioners should say which way their work should develop but can we ever get unity about this? It is always disappointing to find, after much discussion in the National and Medical Press, that meetings are called to discuss matters vital to General Practice : the backwoods doctor appears, he has heard nothing of the discussion at all, and it all has to be explained to him again in words of one syllable, before he dashes off to give the latest wonder drug of which he has heard, Prontosil. Unkind and not really true because such men are dedicated to the welfare of their patients and are blind to everything else.

However, lack of support and unity do not help our case and many of our frustrations we can blame on ourselves. To some extent we know what is wrong but what is it that will attract recruits to General Practice? What would the medical student and young hospital doctor of today like to see there?

'DICONAL' tablets

for the relief of intractable pain – when morphine would normally be given

"Dipipanone ..... has turned out to be the nearest approach to the ideal oral analgesic for patients who wish to be kept alert."

Practitioner (1962), **189**, 198

Each 'Diconal' tablet contains Dipipanone Hydrochloride B.P., 10 mg.—to relieve pain Cyclizine Hydrochloride B.P., 30 mg.—to prevent nausea *and vomiting*

(The precautions and contra-indications are the same as for morphine.
'Diconal' brand Tablets are subject to the D.D.A.)

Indicated in carcinomatosis, after operations, and in patients not responding to morphine or pethidine

Full information is available on request

Burroughs Wellcome & Co., London
(The Wellcome Foundation Ltd.)

REPORT

PSYCHOLOGICAL SOCIETY

Symposium on Psychosomatic Medicine

On Friday, October 27th, a Symposium on Psychosomatic Medicine was held in the Pre-Clinical Classroom, in place of one of the regular Combined Rounds. This is believed to be the first such event to have been completely organized by students. **Dr. David Stafford-Clark,** who acted as Chairman for the afternoon, called it "one further step forward in the history of Guy's student enterprise". He gave a brief introduction to the subject, and stressed the importance of recognising the psychosomatic aspect of all illnesses, rather than a limited number of "psychosomatic diseases".

The first speaker was **Dr. Michael Price,** Consultant Physician at Lewisham, on the subject of Ulcerative Colitis, illustrated by the discussion of two cases. **Dr. Sanderson,** Consultant Dermatologist at St. George's, discussed the subject with particular reference to cases of Rosacea, Neurodermatitis, and Eczema. **Dr. Sullivan** then gave a most informative and stimulating review of the subject of Placebos, their uses and effects. Following a period of discussion, **Guy Williams** presented a case illustrating the importance of psychosomatic factors in its development. The speakers were thanged by **Michael Simpson,** Chairman of the Psychological Society, and were later entertained to sherry in the East Wing.

The Students' Club graciously gave us permission to entertain our guests in the North Common Room, though reminding us to "leave the place reasonably tidy and to ensure that no ungentlemanly conduct occurs". We are pleased to record that our distinguished guests behaved in a thoroughly gentlemanly way. The puritan atmosphere of our festivities was heightened by the arrival, soon after their start, of a man instructed to take the carpet up, to lessen the anticipated damage! In a cool, clinical world, in which it is not always possible to observe the customary politenesses and social niceties, it is impressive to see the Students' Club setting such a shining example of good manners.

M. A. SIMPSON

NOTICES

GUY'S HOSPITAL NURSES' LEAGUE

SIR COSMO AND LADY MABEL BONSOR SCHOLARSHIP

£200 is available for Members of the League to undertake Post-Registration Study at home or abroad. Applications giving details of the Study to be undertaken, should be sent to the Matron and Hon. Secretary, Guy's Hospital Nurses' League, Guy's Hospital, London, S.E.1, by the 31st January, 1968.

HIPPIES v. WEEDS

Your chance to discuss the pros and cons of drugs, in another "teach-in" organized by Guy's Hospital debating society on November 21st, 6.0 p.m. in the Psychology Theatre.

The speakers will be Marcus Upton, M.P., Leon Britten, Steve Abrams and our own Frank Sullivan, B.Sc.

NURSING SECTION

Our Compassion

Twentieth-century man is not easily given to feeling of sentiment and sorrow when he hears of catastrophes and disasters affecting the lives and fortunes of his fellow-beings. He has heard and seen too much: two world wars—the second culminating in the use of nuclear weapons, now known to be capable of annihilating the human race completely—and almost continuous war in some part of the globe for over thirty years, have bred indifference in many, pessimism in the philosopher, and ineffectuality in the cleric.

Amidst all this those who care for the sick, nurses and doctors, seem at times to have been stood on a pedestal in the public mind. *They* still care, *they* are still motivated by vocationary ideals which everyone else has long considered dead. But those of us in these professions know how gullible the public have been in accepting our imputed idealism; we are no longer inspired by the image of the Good Samaritan, with whom we are compared.

This face, as presented to the public, has been dealt many blows in recent years, and the mask shows signs of slipping. Nevertheless, each year brings forth a new crop of young people who aspire to the altruistic ideals they mistakenly expect to find amongst all who nurse the sick. Apart from the exigencies of essential routine, when juniors may find themselves lost beneath the weight of their seniors' superior knowledge, there are always contentions with those whose sole claim to membership of the gerontocracy rests on their assertion that young people "aint wot they used t'be".

The dream is frequently so soon shattered, and second-best is all too readily accepted. Why is this, and why is compassion so unlikely a virtue in the modern world, where it could qualify for so high a place?

This question can, of course, be answered in two entirely separate ways: firstly, by an alteration of the society in which we live, where violence and greed are the only values significantly rewarded, we could create conditions whereby a compassionate consideration for each other would replace this rivalry. However, few of us are likely to agree on the manner in which this aim could be achieved, therefore we are left with the second alternative.

This relies on the strengthening of our own compassionate ideals, irrespective of personal gain. Since none of us are saints, expectation of adequate material awards cannot be put aside altogether. This compromise is a matter of practicality.

Nurses, in common with the rest of the population, are unaffected by the clichés and commendations of our sermonising clerics today. The religious epithet has done its turn; humanist values are foist upon us, unless we wish to lose sight of our ideals altogether. Indeed, nurses and doctors may have been the first to lose faith, perhaps by their very closeness to the cruelty of death, and the realisation of how final it seemed—quite divorced from the Christian view of "passing on".

Relief from pain has been the outcome of man's own initiative, in confrontation with nature. We are thus forced back upon our inner resourcefulness; where experience shows that service for others is the easiest way to promote one's own happiness. No amount of airy idealism will replace this ability to organise our compassion on a level that can be appreciated by the *other* person.

CORRESPONDENCE

Browne, Osler and Guy's

SIR,—Many readers will have been enjoying Mr. William Hill's articles on "Wills Library Antiquities". I was interested in number 8 on "Sir Thomas Browne, Osler and Guy's". As Mr. Hill says, Osler's address, "Religio Medici", to the Pupils' Physical Society was reprinted in the *Gazette*. He will know, but others may not, that it was also published in the *British Medical Journal* (1905, **2**, 993) and that it was referred to on the day after its delivery in the *Pall Mall Gazette* (October 13th, 1905, page 8). It was an important lecture. Osler, a Canadian of Cornish stock, had resigned from the Chair of Medicine at Johns Hopkins University to accept the Regius Professorship of Medicine at Oxford where he took up his duties in May, 1905. Osler had visited England before, but his address to the Pupils' Physical Society was his first public appearance in London after taking up his Oxford appointment. The lecture, and its publication, aroused widespread interest and revealed to a wide British audience the kind of professor that Oxford had appointed.

One week after addressing the Pupils' Physical Society, Osler went to Norwich to attend the celebrations held in association with the tercentenary of the birth of Sir Thomas Browne. A statue to Browne was unveiled opposite the site of the house where he had lived in Norwich, and Osler was among those who spoke during the day's proceedings. Browne's house was destroyed in 1845 and no vestige of it was thought to have survived. In 1962, when rebuilding on the site took place, some remains of Browne's house came to light. I was fortunate enough to acquire a stone from the original kitchen floor. Physicians in provincial cities during the seventeenth century no doubt trod their kitchen floors less frequently than their counterparts of today. But this stone which I possess, together with some letters from Osler to my family, may be thought to constitute another example of "Sir Thomas Browne, Osler and Guy's".

Yours, etc.,

A. BATTY SHAW

41, Newmarket Road,
Norwich, Norfolk.

Old Books—New Books

SIR,—Whilst I would like to applaud and thank the librarian for his fascinating and extremely informative articles on the antiquities of the Wills Library, it does seem to me to be a great pity that so often it is *only* the ancient and out-dated books that are available in the library at all.

This is especially true of the dental section, where it is impossible to refer to modern texts as they are just never there. Is the quest for knowledge amongst dental students so much greater than that of other students or are we simply more selfish and dishonest?

Surely it is not beyond the ingenuity of the library staff to devise some system whereby certain recent books are *always* available, even if it means chaining the precious volumes to the shelves; and also for the minority of students who have these books to return them and show a little more consideration for others.

Yours, etc.,

PHILIP G. BUDDEN

26, Aberdeen Park,
Highbury,
London, N.5.

From Guy's to the R.S.M.

SIR,—I would be grateful if I could use your column to thank all those old Guy's men and women who filled up my questionnaire on pharmacology and therapeutics. The results were most interesting and very helpful, and I hope something useful will come from the discussion at the Royal Society of Medicine.

Yours, etc.,

PROF. J. R. TROUNCE

Department of Clinical Pharmacology,
Guy's Hospital Medical School.

A Light on the Externs' Room

SIR,—I read with interest Mr. J. B. Blaikley's comments on the Externs' Room in the Guy's *Gazette*, September 2nd, 1967. His description of the Externs' Room is both amusing and accurate. Perhaps I may add one small note on the survival of the panels he mentions. During the well-remembered Sunday evening, at the end of 1940, when much of that part of London was on fire, I happened to be driving to Farnborough where we, who were about to be qualified medical students, were living. Seeing that the flames were close to "Ship and Shovel", I naturally drove in that direction to ensure that this "blessed" place was not destroyed. A few people were standing around. There appeared to be no casualties, and as much fire-fighting as possible was being carried out. Tony Lane-Roberts and myself removed the door from the Externs' Room and piled the panels on top, hoping to take them to a place of safety, as part of the College at this time was on fire. The door I remember so well. It had an interesting knocker which we, ourselves, had designed after the fashion of part of the male Anatomy. The solemn procession which followed Tony and myself as we trooped down May's Pond with heads bowed; the door bearing the panels from the walls of the Externs' Room, remains vividly in my memory.

I would be interested to know the whereabouts of the panels today. Also, I hope that they may be resurrected in a suitable place for future generations of Guy's students.

Yours, etc.,

DAVID BURNFORD

Medical Arts Building,
Port Arthur, Ont.

The College and T.B.

SIR,—God bless Mr. M. S. Griffith of "Moonrakers" for his query about T.B. and the College, but may I ask if he had given the matter some thought?

I think Mr. Griffith must be young. Does he know how most Englishmen have lived in the past, and even now on land and sea? The old College was at least dedicated to a purpose and as far as I know watertight.

Yours, etc.,

JOHN C. DOMINICK

Treniffle Lodge,
Lawhitton,
Near Launceston,
Cornwall.

Miss Sidney

SIR,—I should like to record what a wonderful life of service to Guy's, was that of Miss Sidney, Manager of Guy's Hospital *Gazette* from 1934-1961 and Secretary to the Guild of Ex-Patients, since its inception in 1933 until her retirement in September, 1965.

She was unfailing in all aspects of her work, and particularly in her devotion to the welfare of our Guy's Hospital patients, as it was promoted through the Guild.

I knew her for very many years, and am glad to remember with gratitude my long association with her.

Yours, etc.,

EMILY E. P. MACMANUS
President

Terry Lodge,
Terrybawn,
Bofeenaum,
Ballina,
Co. Mayo, Ireland.

Sir Herbert Eason

SIR,—In a recent issue of the *Gazette* of 2nd September last, you stated on page 462 that Mr. (later Sir Herbert) Eason was Superintendent from 1930 to 1937, but in fact he was Superintendent from 1920 to 1937. On the previous page there is also an error as he was Vice-Chancellor of London University whilst still Superintendent, and when he retired from Guy's he became Principal. Although this seems an unusual sequence, it was, in fact, what happened.

Yours, etc.,

J. B. BLAIKLEY

The Superintendent's House,
Guy's Hospital, S.E.1.

The Ban Broken

SIR,—The article "Ban on Women" in the October 28th issue of the *Gazette*, awakened memories of 1944 when, as a Sister Tutor, the Medical School Council allowed me to attend student lectures and to work in the Dissecting Room when, with Matron's encouragement, I read for a London University degree. I can hear Dr. Spurrell (as he then was) saying, "We have got to accept women students in future, Sister—go in and break the ice." So I did, first in uniform and then rather bravely in mufti. How kind everyone was and how I enjoyed it. So may I proudly lay claim to being the first Guy's woman "student" —though not a medical one, I am sorry to say.

Yours, etc.,

NOEL NEILD (née Surridge)
(Guy's 1935-1947)

The Old Rectory,
Colne Engaire,
Colchester.

Simpson on Sterilisation

SIR,—I am surprised to read what amounts to condemnation of male sterilisation by Professor Simpson in your last edition. Surely he realises its social desirability in many cases. I would be interested to know how he considers it might prevent a man serving his sovereign in war.

Yours, etc.,

PAT BROADBENT
Heath Visitor

182, Hollow Way,
Cowley,
Oxford.

Professor Simpson asks Miss Broadbent to read the paragraph again to assure herself he did not condemn the procedure. As to maim, "eunuchs" used *to be thought to be unfit to fight for the Queen: Professor Simpson's article does say "used to".*

Flint followed Flint

SIR,—It may be of interest to you to know that Mr. F. J. Flint, son of the Mr. Flint who started the Dental Laboratory at Guy's in 1907, followed in his father's footsteps, and is still employed as a Dental Technician in this practice.

Yours, etc.,

C. WHAITES

130, Rhodes Avenue,
Salisbury, C.4,
Rhodesia,
P.O. Box 89.

H.O.P. Action—Not Words!

SIR,—I feel sure that Ian Morris would not wish to take any credit for forthcoming improvements to H.O.P.; I can, however, assure the Hon. Sec., Clubs' Union that any such alterations as may occur are long overdue.

The Hon. Sec. states that our budget is limited. Two possibilities therefore remain. Improvements could be made as the budget permits, or secondly, an appeal could be launched to raise money for a new pavilion. There is no doubt that the latter alternative is the most necessary, and it is regrettable that Guy's should lag behind the other four major sporting hospitals. St. Thomas' and St. Bartholomew's have new modern pavilions, and both St. Mary's and The London's have recently been completely renovated and extended. In contrast, our pavilion, as Ian Morris correctly states, smacks of decay and deterioration.

In addition, the administrative attitude appears both complacent and indecisive. Last season, the boiler finally expired in mid-March and we had to wait nine months before a replacement was installed! For the past two weeks, about 50 people have had to wash down under two showers after training—the other shower broke down six weeks ago—and appears to be *sub judice*. For the past two years, staff difficulties have been acute and temporary assistants never remain for long periods; the shortage leads to complaints about curtailment of amenities which have previously always been provided. Finally, those keen and willing to start pre-season training were confronted this season with a closed sports ground because the groundsman was due for his annual holiday and no assistants were available—although we were, with difficulty, able to keep it open.

The Hon. Sec's reply refers to Ian Morris's genuine complaints as "destructive" and "expecting it all to be done for him". I regret that until a tangible effort is made to improve the facilities, those who use the sports ground year in, year out, have every right to complain. The fact remains, and is a source of pride to many, that Guy's possesses a sporting tradition second to none among British hospitals—yet the pavilion is unworthy of the famous players and teams that crowd its walls.

The student sporting body can only draw attention to these deficiencies—we are powerless to implement changes. But surely all involved have a similar purpose—namely to revive the name of Guy's in the sporting world. This season, the rugby XVs have been consistently recording victories at all levels, and at last the 1st XV fixture list again resembles that of a first-class club—already with the scalps of Cambridge University and Bedford under our belt! The hospital teams can strive their utmost, but unfortunately as winter draws in and the harsh conditions now prevalent at H.O.P., the number of participant dwindles, thus diminishing our vital reserve strength. Evening training is less enjoyable and fitness declines with the result that our true potential is never realised.

The solution revolves around the significance of sport to the sporting administrators at Guy's. There must be many who still remain very interested—whether actively or passively—and a whole host of ex-Guy's men who note with pride the growing status of the rugby club.

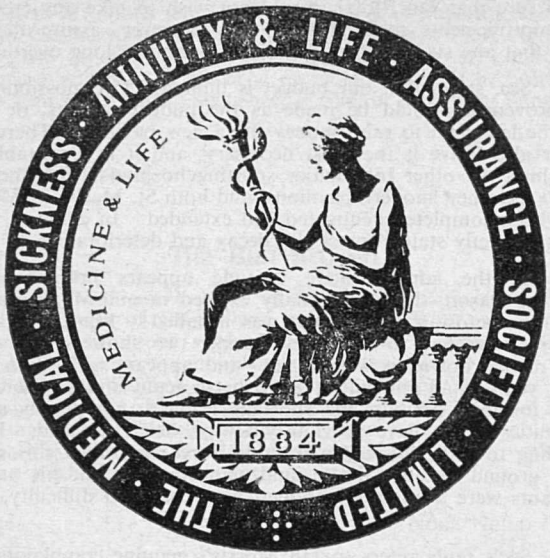
The time for positive action is long overdue. It is both important and urgent because we have an obligation to maintain and uphold the sporting achievements of our predecessors and to provide for and encourage our successors.

Next year, the Guy's R.F.C.—the oldest and one of the most famous rugby clubs in the world—play a guest side to celebrate our 125th anniversary. It would be disgraceful if we entertained them in one of the most decadent sports pavilions in the world!

Yours, etc.,

H. C. SHARP

East Wing,
Guy's Hospital, S.E.1.



The Doctors and Dentists own Insurance Company

Sickness and Accident Insurance
Permanent Policies to meet the special needs of the Medical and Dental Professions.

Family Provision Assurance
A tax free income for your family in the event of death.

Life Assurance
Capital for retirement and security for dependants in the event of death.

The Combined Policy
Three Policies in one—Permanent Sickness and Accident Insurance, Life Assurance and Family Provision Assurance.

Foundation Policy
A foundation on which students and newly qualified Doctors and Dentists can build to obtain a combined policy. Cover against incapacity and death at very low cost with the right to convert to a normal policy later.

The Medical Sickness Annuity and Life Assurance Society Limited

P.O. Box 449, 7-10 Chandos Street, Cavendish Square, London, W1. Tel: Museum 1686

SPORT

UNITED HOSPITAL R.F.C. CENTENARY SEASON

On Wednesday, November 17th, a Centenary Match will be held under floodlights (k.o. 7 p.m.) at Crystal Palace National Recreation Centre. This will be followed by a Centenary Dinner at the N.R. Centre.

The President (Mr. T. L. T. Lewis) has selected a side to play against U.H., and includes several players who have played for Guy's in recent seasons, viz. W. T. Treadwell, D. A. Biggs, J. A. Edgar, and J. E. Davies.

The United Hospitals' XV includes six of the present Guy's XV, D. R. Elliott, C. G. Neville, T. F. Price, B. J. Rowlands, P. G. F. Swift, C. W. Thorburn.

RUGBY

Guy's followed their victory over Cambridge University by beating Bedford by 8—0. Their opponents lacked both leadership and co-ordination, and Novak and Neville provided the necessary points. Elliott converted one try. Dr. J. E. Davies has rejoined the Guy's front-row despite the London Welsh News recording recently that he was in pursuit of a London Welsh 1st XV place. Cockburn has departed temporarily to Mombasa, but Neville moves up to 2nd row and M. Forbes from Cambridge joins Thorburn and Curson.

Thorburn, again captaining Middlesex, scored a personal triumph by defeating a Kent side containing five Guy's players—Beacham, Rowlands, Swift, Hey, and C. Neville.

C. W. Thorburn has been selected to play for the Anglo-Scots in the first Scottish Trial on Tuesday, November 7th.

Guy's, lacking considerable interest and energy (in a morning game), beat Old Blues 16—3.

GOLF

Guy's won the Hospitals' Golf Cup against Middlesex at Wentworth 3—2 on October 20th. The students were less successful against the President's team at Tonbridge Golf Club in May and against the Staff at Huntercombe in July; in both matches being beaten decisively. The students regained the Beveridge Cup at the University summer meeting. At the A.G.M. on October 27th, A Philips was elected Secretary and N. Curry Captain for the following year. The Club looks forward to a happy and successful season next year. During the winter months the Club hopes to organise a film shot of a famous professional golf tournament.

DIARY

RUGBY

Nov. 11.—Wasps—Sudbury.
,, 25.—Cheltenham—Cheltenham.

SOCCER

Nov. 11.—U.H. Cup, Round 1—R.D.H. A.
,, 15.—University College. A.
,, 18.—Old Malvernian II. H.
,, 22.—King's College. H.
,, 25.—Woolwich. H.

HOCKEY

Nov. 11.—Wimbledon 2nd XI. A.
,, 18.—Gravesend. H.
,, 25.—Surbiton 2nd XI. A.

RUGBY

GUY'S v. CAMBRIDGE UNIVERSITY

At Grange Road 14th October, 1967

Result: won 8—0

Guy's Hospital recorded their first victory against Cambridge University since 1947 on October 14th, when they defeated their opponents 8—0. The last Hospital win—16—8 occurred at H.O.P.; in the intervening period, however, Guy's could only score 43 points, whereas Cambridge University amassed a total of 483 points—an average of 27 points a match! Although the corresponding match last year was evenly balanced and Cambridge were considered fortunate to earn an 11—9 victory, the previous post-war encounters provided runaway victories for the University.

The 1st XV showed two changes John Davies, the 1965 Cup-winning captain, returned to add his experience and weight to a very young and light front-row, and Dave Elliott, having recovered from a temporary loss in goal-kicking ability, returned to the full-back position.

From the kick-off, Guy's were immediately rushed out of their stride; the Cambridge attacks were, however, too individualistic and sterotyped but Swift and Elliott were able to keep Guy's out of trouble. The first half was scrappy, with both sides finding difficulty in controlling a slippery ball, and the majority of attacking moves were blotted out by keen covering. Guy's adapted themselves more quickly to the conditions and the first dangerous attack arose from a long Swift grubber which took play to the Cambridge "25". A scrum ensued; the ball was lost but the Cambridge centres were tackled in midfield and a Cambridge offence left Elliott with a straight 30 yard kick. On such an important occasion, with much at stake, Elliott kicked high but wide. From that moment, however, he never put a foot wrong, tackling and covering immaculately, and on many occasions catching and kicking to touch in one movement with the opposition breathing down his neck; he completely overshadowed his opposite number.

Within seconds, Novak put Guy's back on the offensive with a powerful bullocking run, intelligently completed by a grubber kick to the right hand corner. The five yard scrummage was heeled by Guy's and without further ado and to the amazement of all, they swept the larger Cambridge pack back and over the line for a push-over try. Elliott placed the ball five yards in from touch and his conversion soared between the posts. When last did Guy's score a push-over against Cambridge? During the first half the only Cambridge threats arose from a misjudged up and under and a Cambridge interception following a half-break. A more dangerous occasion was well read by Elliott who charged up from full-back to bowl over the strong Cambridge centre, Price, as he ran on full burst for a gap. Following the push over try the Guy's pack grew in stature, with C. Neville and Cockburn magnificently controlling the line-outs, and Curson giving his fly-half no respite.

Indeed, Guy's were unlucky not to score again, for a high New Zealand "box" kick took the Hospital to the Cambridge line, and later a classic Cheeseborough dummy sent his centre pirouetting towards the centre spot, but the Cambridge cover soon pulled him down. The half-time score of 5—0 may not have reflected the territorial advantage held by Cambridge, but the Guy's effort made them a constant threat whenever they were given any room in which to manoeuvre.

In the second half, Guy's assured growing dominance of the game both in tight play and in the loose, where they capitalised on the increasing number of dropped passes and general indecisive play of the University. With 15 minutes remaining, a final Cambridge assault was spoilt by a knock-on with a "man over" and secondly by an unsuccessful long-range penalty attempt. Within moments, Guy's were awarded a penalty 30 yards out, and 10 yards in from touch, and Elliott crowned a great display with three more invaluable points.

In the dying moments, the small but vociferous contingent of Guy's supporters watched anxiously for the end—but they need not have worried. The Cup had been dashed from our lips last year, but now they were in no mood for compromise and they harassed and harried their opponents back on to their own line until the final whistle brought relief to Cambridge and sweet victory to Guy's—8—0.

H. SHARP

SOCCER

Premier Division U.L.

GUY'S v. L.S.E.

Saturday, 14th October, 1967
Result: lost 0—4

For the first time in their history, Guy's 1st XI were to play in a University League against one of the top University sides.

Only ten men turned up, a rugby player, Bruce Wright, making the eleventh.

Once again there was no referee, so the opposition's substitute took the whistle; which in itself decided the way play would go.

Guy's played good, hard football, but lacked finishing. An early mistake by Carter and Watt-Smith gave L.S.E. the lead. Guy's equalised five minutes later through Harrison, but the referee disallowed the goal. This bad decision upset the home side, who never settled down after this point.

The Guy's defence played well, but could not hold the fast and strong L.S.E. attack, who were two up at half-time, and four at the final whistle.

Evans took the honours for the home side, in a very hard match.

Guy's: Carter; Davy, Evans; Nash, Watt-Smith, Lovell; Hutchinson, McClure, Harrison, Lindridge, Wright.

GUY'S v. KING'S COLLEGE HOSPITAL

U.H.L. Wednesday, 25th October Away

As usual, Guy's took the field with only 10 men, who included several second team players. The early play was scrappy, but gradually Guy's settled down against the mediocre opposition. The arrival of the 11th man coincided with the opening of the scoring. An Elias shot was only half stopped, and Leeburn, following up intelligently, casually volleyed the ball home. The Guy's team continued to press but poor finishing did not bring the goals. Five minutes before half time, two lapses by the Guy's defence allowed K.C.H. to take the lead. The first goal resulted from a free kick with Wood unsighted by the defensive "wall". The second goal was due to bad covering by the half-backs, allowing the opposition an easy goal.

In the opening minutes of the second half, Guy's failed with two open-goal "gifts". The pattern continued, with all the forwards, including even the normally dependable Elias, guilty of failing to take easy chances. The game ended on a farcical note with the awarding of a penalty to the opposition by the amateur referee. This was not met kindly by

the Guy's defence, but their anxiety was subdued when the opposition inside-forward put the penalty kick over the bar.

This was a miserable performance by the Guy's team, who paid the penalty for absolutely pathetic finishing and the gift of two goals to the opposition. One can only hope that the return of the 3 Guy's players—Lindridge, McClure and Watt-Smith—from U.H. duty, will result in better performances, for surely it cannot become much worse.

Team: J. Wood, R. Davey, P. Evans, S. Milnes, I. Nash (Capt), R. Lovell, D. Jacobs, I. Harrison, D. Ward, E. Elios, R. Leeburn.

R. LOVELL

U.L. CUP PRELIM ROUND
GUY'S v. SIR JOHN CASSCOLL

Away Saturday, 28th October, 1967

The Guy's team arrived at the Sir John Cass ground after negotiating what must be one of the most hazardous approaches to a pitch in the country. Once it had been decided that the game could be played, the home side kicked off in the proverbial atrocious conditions.

Both sides settled down quickly, and the Guy's defence played solidly to contain the opposition's opening attacks. Few clean chances were made but a hard shot, on the turn by Milnes was well saved by the Cass goalkeeper. Watt-Smith moved up frequently to add some punch to the attack, but first-time clearances by the uncompromising Cass defence nullified any attempts to score by passing movements.

At the start of the second half, a heavy hailstorm, which later turned to icy rain, worsened the conditions, and after a few defensive slips, Nash and Evans were forced to clear awkward breakaways with unsophisticated clearances.

Hutchinson and Jacobs were linking well on the right wing but slowness in centring gave Harrison insufficient space to be effective in the middle. Taylor had been detailed to "mark" the "Danger Man" of the Cass attack, and soon, with some pressure taken off the defence, Guy's mounted a series of attacks.

Eventually, Lovell forsook his defensive rôle to burst through the middle and jink past a defender before firing in low shot which cannonned off the centre-half into the net. This virtually settled the matter and Guy's were unlucky not to score again before the game ended in near-darkness and pouring rain.

Team: D. Lindridge; P. Evans, K. Taylor; R. Lovell, S. Watt-Smith, I. Nash; J. Hutchinson, S. Milnes, D. Jacobs, I. Harrison, R. Leeburn.

R. LEEBURN

HOCKEY

GUY'S v. NUNEATON

Home 21st October, 1967

Result: won 4—0

As this was the final day of the Pre-Olympic hockey tournament it was felt by the H.A. that a number of Midland and Northern clubs would like to come to London for a game in the morning and then watch the tournament in the afternoon. This was how with some masterly organising, by our Fixture Secretary, Guy's was paired up with Nuneaton.

From soon after the Whistle went it was obvious that Guy's were the better side in all departments of the game, the forwards really looked like an attacking line and whenever the ball got through, our defence dealt with it quickly and cleanly. Goodhart scored the first goal with a narrow angle shot from the right wing. Kendrick at last managed to score from a short corner ! Owen and Turfitt completed the scoring. The latter making a welcome comeback to the hockey circle after a sabbatical work year. In the last half Guy's were hardly ever out of their circle and although this was very heartening it was a little disappointing that Guy's did not score more.

It will be interesting to see how Guy's fare against slightly stiffer opposition.

Team: C. Calder; D. Crafts, R. Nickalls; R. Kenderick, C. Pearson, V. Harvey; R. Goodhart, T. Owen, N. Turfitt, S. Cripps, T. Godfrey.

On Wednesday an A XI beat Charing Cross Hospital 4—1. Scorers Cripps 2 Goodhart, Dodd.

S. W. CRIPPS

WATER POLO

UNITED HOSPITALS LEAGUE

Result: won, Guy's, 9;London Hospital, 5
Tuesday, 24th October

Guy's won their first game in this season's U.H. League against their old rivals the London Hospital.

Guy's combined well in mid-field and their marking was tight which is essential when playing in the small pool at St. Mary's Hospital.

It took some time for the London to settle down and during the first quarter Guy's scored three goals through Froom and Challacombe. In the next two quarters the London came more into the game but could not pierce the strong Guy's defence: Guy's going further ahead from two goals by Challacombe, one from Foulds and one from Northcott, who scored his from a fine break up the pool and a shot which gave the goalkeeper no chance.

Being 7-2 down in the last quarter the London threw everything into attack and scored three quick goals. However, some fine goalkeeping by Howard and two further goals by Challacombe made the game safe for Guy's.

The prospects for this season seem good especially as the team gets fitter, but St. Mary's once again appear a team to be reckoned with.

Goalscorers: Challacombe 5, Froom 2, Foulds 1, Northcott 1.

Team: S. Challacombe, A. Froom, D. Foulds G. Northcott, K. Howard.

A. R. FROOM

GOLF

Semi-final of the Hospital Golf Cup against St. Bartholomew's Hospital

October 20th, at West Course Wentworth.

The full Guy's team arrived at Wentworth at 9.30 a.m. D. Adams teed off hitting an immaculate drive down the first fairway. He continued to play in the same vein all morning beating his apponent 3 and 2. He remarked afterwards that he played quite well. (after qualification celebrations the previous night). P. Ellis our lovable retiring Captain was immediately recognisable in his swave plus-fours. The rest of the team were a little troubled by his first drive; they need not have worried his golf was far too good for his opponent who was eventually overwhelmed at the fifteen hole. D. Elliott having a welcome respite from the larger ball, had a little problem for the first

It took about five minutes, three pounds, and a handshake to open an account with Barclays.

The five minutes were mainly spent in writing a couple of specimen signatures and in giving the name of a suitable reference. The three pounds—all I could bank at the time—were received with a cordial handshake and I was made to feel really welcome. Nothing stuffy about Barclays. You don't believe us? Try 'em.

BARCLAYS BANK

Money is our business

few holes, not having played the course. He beat the Bart's captain with a series of four pars on the last four match holes. A. Phillips played a round of golf which all golfers have once in awhile best described by the dictum "He played a lot of golf". Your correspondent played his usual miserable game and was lucky to win, being 2 holes down with 3 to play. The team retired to lunch in preparation for the afternoon's final against the Middlesex Hospital.

Result: won 4—1. (Guy's player first.)

D. Adams v. D. Grieve won 3 and 2, P. Ellis (capt.) v. S. Davidson won 5 and 4, D. Elliott v. A. Hoppe won 3 and 2, A. Phillips v. C. Booth lost 6 and 4, N. Curry v. H. Rutherford won 1 up.

Final against Middlesex Hospital on East Course at Wentworth

Suitably refreshed after lunch, D. Adams teed off, producing a typical par four in the conventional manner; he played very well that afternoon going round the course in 69, which is par. This was typical of his fine golf at the Hospital; in fact, he has never been beaten in a Cup match playing for Guy's. P. Ellis also played his last game for the Hospital side; he went to the turn being two up, playing a very determined opponent who eventually succumbed to a fine par four at the long sixteenth. P. Ellis went around in a score of 72. D. Elliott played remarkable golf in the afternoon at the 525 yard 9th hole on a wet fairway reaching the green with a drive and a seven iron! He went from strength to strength with a birdie to finish his opponent at the fifteenth hole. A. Philips was a new man in the afternoon, and after a very dogged battle with the Middlesex Captain, eventually lost on the 18th hole. Your correspondent met an opponent who played far superior golf. Guy's have now won the Cup ten times in the last twelve years, unbeaten in cup games since 1963.

Result: won 3—2

Final (Guy's player first).

D. Adams v. B. Williams, won 5 and 4. P. Ellis v. J. Spillone, won 3 and 2. D. Elliott v. A. Richards, won 4 and 3. A. Philips v. P. McGorley, lost 1 hope. N. Curry v. R. Vassal-Adams, lost 5 and 3.

N. CURRY

HOSPITAL INFORMATION

APPOINTMENTS VACANT

GUY'S HOSPITAL

Applications are invited for the appointment of **Registrar in the department of Conservative Dental Surgery** with attendance on five sessions per week with duties commencing as soon as possible. Forms of application are obtainable from, and should be lodged with, the Superintendent, Guy's Hospital, London, S.E.1., not later than **Monday, 20th November 1967.**

GUY'S HOSPITAL S.E.1.

Applications are invited for the post of **Registrar in Psychological Medicine,** with duties to commence on 1st December 1967 and appointment until 30th September, 1968 in the first instance. Forms of application are obtainable from the Superintendent, Guy's Hospital, S.E.1., and should be returned not later than **14th November, 1967.**

GUY'S HOSPITAL S.E.1.

Applications are invited for the post of **Registrar in Dermatology** with duties to commence on 1st December, 1967 and appointment until 30th September, 1968 in the first instance. Forms of application are obtainable from the Superintendent, Guy's Hospital, S.E.1. and should be returned not later than **14th November, 1967.**

GUY'S HOSPITAL S.E.1.

Applications are invited for the post of **Senior Registrar in Ophthalmology** (three sessions per week) with duties to commence on 1st December, 1967 and appointment until 30th September, 1968 in the first instance. Forms of application are obtainable from the Superintendent, Guy's Hospital, S.E.1. and should be returned not later than **14th November, 1967.**

GUY'S HOSPITAL S.E.1.

Applications are invited for the post of **Staff Dental Officer** to Guy's Hospital (General Dental Practitioner Grade) for up to nine sessions a week from February 1st, 1968. Applications giving details of age, qualifications and experience together with names of two referees should reach the Superintendent, Guy's Hospital, not later than **November 24th, 1967.**

PASS LISTS

UNIVERSITY OF LONDON

PhD.

Medicine

R. C. D. W. Bandaranayake — F. B. Gianelli

PhD.

Science

N. Ahmad — J. C. W. Shepherd

M.Sc.

A. J. Rainbow

ROYAL COLLEGE OF SURGEONS OF ENGLAND

Final F.F.A.

J. F. Muray — D. G. nancekievill

J. A. Bushman — R. W. Hall

Primary F.F.A.

M. B. Barnett — D. J. Openshaw

T. J. B. Harris — G. Smith

UNIVERSITY OF CAMBRIDGE

Examination in Pharmacology for Medical and Surgical Degrees

M. E. Taylor-Pearce

UNIVERSITY OF OXFORD

2nd B.M. Examination

J. P. Miller — J. Reeve

R. A. Oxlade

PUBLICATIONS BY GUY'S MEN

Blackwell, B. and Another. Aspects of psychopharmacology. *Proc. R. Soc. Med.*, 1967, **80**, 830.

Blackwell, B. and Another. Early evaluation of psychotropic drugs in man. *Lancet*, 1967, **2**, 819.

Bradlaw, Sir R. Milestones. *Brit. Dent. J.*, 1967, **123**, 340.

Davis, H. C. The dentist and the world around him. *Brit. Dent. J.*, 1967, **123**, 345.

Everall, J. D. Mycological and clinical evaluation of griseofulvin for chronic onychomycosis. *Brit. Med. J.*, 1967, **3**, 464.

Gibb, D. H. A simple screw-holding screwdriver. *Brit. Dent. J.*, 1967, **123**, 350

Haines, D. H. Dental identification in the Stockport air disaster. *Brit. Dent. J.*, 1967, **123**, 336.

Hallpike, C. S. Some types of ocular mstagmus and their neurological mechanisms. (Hughlings Jackson Lecture.) *Proc. R. Soc. Med.*, 1967, **60**, 1043.

Hern, J. E. C. Inhibition of true Cholinesterase in TOCP poisoning with potentiation by "Tween 80". *Nature*, 1967, **215**, 963.

Hopkins, P. The use of local injections of hydrocortisone in general practice. *Proc. R. Soc. Med.*, 1967, **60**, 975.

Kendall, P. H. Car seats and back-ache. *Proc. R. Soc. Med.*, 1967, **60**, 958.

Jarrett, R. J. and Cohen, N. Intestinal hormones and plasma-insulin. *Lancet*, 1967, **2**, 861.

McColl, I. The site of absorption of vitamin B(12) in man. *Brit. J. Surg.*, 1967, **54**, 841.

Neill, D. J. Studies of tooth contact in complete dentures. *Brit. Dent. J.*, 1967, **123**, 369.

O'Brien, M.D. and Veall, N. Cerebral cortex perfusion-rates in extracranial cerebrovascular disease and the effects of operation. *Lancet*, 1967, **2**, 392.

Oppé, T E. and Another. Megacolon and megarectum in older children and young adults. *Proc. R. Soc. Med.*, 1967, **60**, 803.

Pickard, B. H. The prognosis of Meniére's disease. *Proc. R. Soc. Med.*, 1967, **60**, 968.

Pickard, B. H. and Another. Operations on the saccus endolymphaticus for the relief of Meniére's disease. *Proc. R. Soc. Med.*, 1967, **60**, 966.

Ross, D. N. Homograft replacement of the aortic valve. *Brit. J. Surg.*, 1967, **54** 842.

Smith, R. Advances in general practice *Practitioner*, 1967, **199**, 541.

Spector, R. G. and Watts, D. C. Evidence for the random aggregation of sub-units to produce multiple forms of lactate dehydrogenase in the brains of rat and man. *Nature*, 1967, **216**, 154.

Thompson, A. Paralleling in conservative dentistry. *Brit. Dent. J.*, 1967, **123**, 328.

PERSONAL

BOURNEMOUTH, HANTS.—Associate required for fully equipped second dental surgery. Salary on high percentage basis. Full Clinical Freedom and chairside assistarce Box No. 1/11.

GUY'S GRADUATE, 1955—Requires assistant with definite view for single-handed expanding practice in rapidly-growing area ten miles from Adelaide. Interest in obstetrics or anaesthetics an advantage. For further information apply: David Gill, M.B., B.S., D.C.H., Box 55, Tea Tree Gully, Southern Australia 5091, or Jimmy Goodliffe, Appointments Bureau. Guy's Hospital.

PRACTICE—Retiring Guy's man has leasehold lock-up Dental practice for sale—West Sussex, seaside. Annual audited gross £6,700 on 4½ days weekly. Photographs of premises and equipment available to genuine enquirers. £3,325 inclusive, Hole, 55, Hayling Rise, Worthing.

WANTED—Conservation Kit. Please contact E. P. Brown by note in Letter Rack, East Wing.

CHANGES OF ADDRESS

Dr. R. M. Corker, 152, Gregory Avenue, Weoley Castle, Birmingham, 29 (Tel: 021-475 1310)

Major R. C. Francis, Hartswood Manor, Sidlow, Nr. Reigate, Surrey.

Mr. and Mrs. P. J. Haworth, L.D.S., R.C.S. 4 Park Lane, Woodstock, Oxfordshire. (Tel: Woodstock 7312); and 107, Harley Street, London, W.1.

J. A. Howard, Esq., L.D.S., R.C.S., B.D.S., 16, Northern Avenue, R.A.F. Henlow, Beds.

Dr. and Mrs E. A. Humphrey 6, Cringles Park, Silsden, Nr. Keighley, Yorks. (Tel: Steeton 3248)

Miss Jean Ludlow, Nurses' Home, Southmead Hospital, Westbury-on-Tryn, Bristol.

John and Barbara Parkholm, Jonbar, 70, Clifford Road, Poynton, Cheshire. (Tel: Poynton. 5771.

Sheila M. Pegg (Mrs.), 14, Linwood, Van Torts Farm, Sawbridgeworth, Herts.

Mr. O. H. Shaheen, 37, Harley Street, London, W.1. (Tel: Welbeck 7828)

Mr. and Mrs. J. D. Wonham, 291, Lonsdale Road, Barnes, S.W.13. (Tel: 876 7271)

BIRTHS

EVERETT—On October 2nd, to Eithne (née Bolger) and Paul Everett B.D.S. L.D.S. a daughter Elizabeth Clair, sister to Stewart and Marcus.

MAGELL—On October 16th, at Beardwood, Blackburn, to Naida (née Payne), wife of Mr. Jack Magell, a daughter, Tanya Jane.

SELLMAN—On October 30th, at St. Andrew's Hospital, London, N.W.2, to Ingrid, (née Finer) and David Sellman, a daughter Debra Danielle

STEYN—On August 30th, at St. Mary's Hospital Portsmouth Hants. to Barbara and Michael Steyn a son Matthew Edward, brother for Richard.

WINSKILL—On September 2nd, 1967, at Cuckfield Hospital, to Maureen (née Hutton) and Andrew Winskill a daughter, Clare Louise.

GUY'S HOSPITAL GAZETTE

EDITORS D. S. ROBINS and C. B. BROWN
SPORTS CORRESPONDENT J. G. PAYNE
NURSING CORRESPONDENT E. A. MALPAS

FORTNIGHTLY TWO SHILLINGS VOLUME 81 NUMBER 2070

The opinions expressed in these columns are solely those of their authors and are not to be taken as the views of the Hospital as a whole.

PASSIM

A Service or Not

The National Health Service debate is now being officially entered into on the part of the Government, through its representative on earth, Mr. Kenneth Robinson, with a view to making changes in its administrative structure.

"I intend to consider a number of possibilities carefully before I make my own tentative proposals. I shall aim in due course, but not for some months, to set out my views, probably in the form of a Green Paper, as a basis for public discussion and wide consultation.

"I shall also look forward to hearing the comments of honourable Members. Only after this process of consultation will the Government finally make up its mind and introduce legislation, if that is necessary."

The impression with which one is left with this statement made in the House of Commons, is that the Government regards this task with little of the importance it deserves in so far as it is to be reviewed in such a leisurely fashion. In addition, there is the lingering suspicion that the Government has little or no intention of really putting the service in order.

The idea of a Royal Commission to investigate the N.H.S. independently and impartially has been ignored and this does not inspire confidence that the review will be really a radical one.

The Service itself is becoming gradually more and more inefficient and out of date and morale is depressingly low.

Probable proposals in the end will be to end the "tripartite" system, whereby general practitioners, hospitals and public health services are responsible to different authorities.

A likely step will be to adopt the proposals of the Porrit Committee which as far back as 1962 suggested area health boards with power to control all medical activities within their given boundaries.

However, a strong case is growing to integrate the Ministry of Health with that of Social Security as a public corporation to

administer the whole service in a business-like manner, thus relieving the Minister of a good deal of responsibility whilst leaving him with overall statutory charge. The charge of "overcentralization" at such a suggestion is sure to arise—but the situation is reaching a stage of bankruptcy and as such is in need of strong centralized control. Desperate situations often require desperate remedies.

Tercentenary of Blood Transfusion

It is to Jean Denis, Professor of Philosophy and Mathematics at Montpellier and Physician to Louis XIV that the first attempt and description of therapeutic blood transfusion of man is ascribed. This was communicated by him in a letter which appeared in the *Philosophical Transactions* of the Royal Society of London in July 1667. The operation was the successful transfusion of blood from the carotid of a lamb into a vessel of the arm of a youth who had suffered 20 bleedings for "a contumacious and virulent fever".

However, the process of transfusing blood between two animals had already been described by two Englishmen—Dr. Edmund King and Dr. Lower. The investigation having been originally initiated by Dr. (later Sir Christopher) Wren, who suggested injecting various liquors, such as milk or beer, into the circulation of animals.

Denis, however, in his letter emphasized that the conception of transfusion had originally come from England. He later performed further transfusions from animal-to-man, and one patient, suffering from "an inveterate phrenzy", showed all the signs of having received a considerable amount of incompatible blood, exhibiting pain in the arm, a rapid and irregular pulse, sweating, pain in the back, vomiting, diarrhoea, and finally passing urine almost black with haemoglobin.

However, it was not until 1818, almost 150 years later, that James Blundell, obstetrician to Guy's and St. Thomas's Hospitals, described in a paper delivered to the Medico-Chirurgical Society, the first blood transfusion from man-to-man. This was the true beginning of modern therapeutic transfusion.

Bread Throwing?

When is a Medical Student not a Medical Student? The answer, according to popular supposition, is "When he is well behaved". The image of a Medical Student has always been rather tarnished. It has been explained, or excused, by many as the result of the long hours, the strange nature of his occupation, and the satisfying of all the wayward sides of his character before he dons the sober garb of a Registered Medical Practitioner and grows serious in the face of all that that entails.

It has always been so in the the popular imagination, carefully nurtured by the books written about and around Medical Student life.

Whether in the hilarious atmosphere that surrounded Dr. Sparrow, or in the romantic-nonsense atmosphere of the sort that persuades nurses that the only object in working at one of the larger teaching Hospitals is to "win" the most eligible, i.e. the most rugger playing, the most beer drinking, and the least working, bachelor of the highest rank available.

The effort to maintain this image has exhausted many good men and it is *almost* with sorrow that one must report how they had fallen behind in recent years. Things are never what they used to be. When was bread last thrown round the dining room? (See a letter in the 1922 *Gazette*) How long is it since meals were eaten "to the accompaniment of a demoniacal orgy of plate smashing and table turning"?

We should not be ashamed of this apparent neglect of the preservation of this boorish image. We should feel a small surge of pride that more people are concerned with the sad plight of the Drug Addict than with the result of the 3.30 at Kempton; that we are as aware of the political situation in Greece as we are supposed to be of the quantity of beer beneath our belts.

There are still, it must be confessed, those amongst us who disrupt the peaceful order. But the weight of public opinion is heavily against them.

GUY'S DIARY

NOVEMBER

25th	S	10.00	Clinico-Pathological Conference, Clinical Theatre.
28th	Tu	1.00	Clinical Lecture. Dr. BISHOP. "Gynaecological Endocrinology."
30th	Th	1.00	Clinical Lecture. Mr. LAWRIE. "Rectal Agenesis."

DECEMBER

1st	F	1.00	Clinical Lecture. Prof. BUTTERFIELD.
7th	Th	1.00	Clinical Lecture. Prof. POLANI. "The Brain and Chromosomal Abnormalities."
		7.45	Music Club. Christmas Concert in Southwark Cathedral. Beethoven's 2nd Piano Concerto. Haydn's Nelson Mass. *(See p. 638).*
8th	F	7.30	Carol Service. The Chapel. Speaker: Rev. M. J. Wilcock.

CURRENT MEDICO-LEGAL PROBLEMS

6. DEPENDENCE ON DRUGS

England largely escaped the menace of drug peddling and the degradation of addiction between the wars owing to the tight laws on the import and possession of hard drugs—opium, morphine, heroin, cocaine—and a careful watch on their prescription by doctors : only some 60 or 70 "addicts" were known and the habits of the Near East in hashish and of Orientals in opium attracted very few. But in the last ten years or so the long-haired, indolent adolescent and his pop girl, the unwashed anti-socials, have been exploring the thrills of "pot" or "weed", the weird hallucinations of "acid" parties (L.S.D.) and the turmoil and tranquility of the "goof-pills", "purple hearts", "french blues" or "black bombers": it has become "the way" to get "high" or be "blocked"—often in the murk of coffee cellars or all-night "beat" sessions. Pedlars who could live on goof pills at 1/- to 2/- each or "reefers" at 7/6 could rely on a steady supply either from hi-jacked lorry loads, "break-in" deals, or the incredible laxity of doctors—and hospitals—in keeping and dispensing their drugs. A canteen worker at a London hospital was found recently to be selling soneryl stolen from the dispensary over the Out-Patient coffee bar at 1/- a pill: a doctor set up his practice in the supply of prescriptions in a Baker Street Underground shop, and an old Harrovian admitted giving way to the pesterings of a girl of fifteen who wanted amphetamines to soothe a boy friend's anxieties.

There is growing evidence that as the novelty and thrill of "pot" and pep-pills wore thin, the danger of wanting the stronger L.S.D. or a "jag" of something more powerful—morphine or heroin, grew : "joy" popping was sought because "coming down" out of the amphetamines was too depressing for words. A dependence was developing—and couldn't be resisted. "Main-line" (vein) shooters, common enough in the States, began to make their appearance in England and the more serious physical dependence that ensued became more widespread. The older W.H.O. distinctions between *"habituation"* and *"addiction"* to drugs has dissolved in a rising stream

of evidence that there is no real clinical difference of any importance: the word "dependence" has sufficient meaning.

Restrictions by law, at one time strict only in respect of the so-called "Dangerous Drugs" have had to be extended to cover an increasingly large number of obviously dangerous habit-forming preparations—from amphetamines and cannabis (marihuana or "weed") to L.S.D. and methadone and the like. The statistics have naturally increased *pari passu* but, more disturbingly, they have also risen in the older "hard" drugs of addiction—and young people show up badly in this increase. Even public schoolboys have lately entered the lists, and there is considerable evidence to link drug-taking with delinquency and the swelling crime statistics. What are the figures?

Statistics

The Home Office keeps a watchful eye on the prescription of habit-forming drugs by (a) inspection of doctors' and chemists' records, and (b) by having reported any convictions of their misuse. The law, it is hoped, will restrain both patients and doctors, but extraneous sources, unlawful importation, thieving and peddling are more difficult to control. Until 1960 the official numbers of persons receiving regular hard drugs had, for some years, been around 300-400, but by 1962 it was over 500, by 1964 over 700 and last year, 1966, it rose to the alarming figure of 1,139 : of these, 749 were heroin addicts (*of whom "about* 200" *were under* 20 *years of age*). Behind these lay more whose activities were bound up with "the trade". This may be nothing by Chinese or American standards, but it is the rate of increase that has alarmed everyone. The adolescent who is drawn into "beat" company may at first only take amphetamines or have a go at "pot" or "weed" for the kick—so as to be "in": week-end cellar or disco-theque parties are a fine soil for the pedlar of drinamyl pep pills ("purple hearts" or "french blues") and "goof-balls" of barbiturates, but it is not long before those who'd like to try it have a "reefer" of cannabis (marihuana), L.S.D. 25, "post" (unlaced capsules of poppy head), or the real "high"—a "jag" or shot of heroin ("joy-popping") often with a much adulterated drug when it comes from the pedlar. Once the "buzz" of heroin has been experienced the victim is really "in", for of all drugs this is the most compelling, and in order to get the stuff (or the money for it) any kind of lying, forgery of prescriptions, thieving, prostitution are common-place. I recently had a case where a woman visiting a doctor always took a child with her and got the doctor to "show" it to the toilet while she stole EC 10's with the doctor's signature impressions making forgery easy for her. The need for doctors to be on the alert is paramount.

Among all age-groups, the distribution of the "hard" drugs in this country is roughly as follows :—

Table 1.

Drug Addiction M.O.H. Current Figures

	1950	1960	1964
Morphine	139	204	*c* 200
Heroin	43	68	342
Cocaine	**9**	**30**	**211**
Pethidine	34	116	
Methadone	5	51	no significant change by 1964
Levorphanol	—	16	
Phenadoxone	3	21	
Dextromoramide ...	—	4	
Dipipanone	—	1	
Dihydrocodeinone ...	1	1	
Dihydromorphinone ...	3	3	

How many adolescents are "in" no one knows—but too many, and the figures for the "soft" drugs are quite beyond computation. The evidence drawing a thread through the long-haired weed smoker or amphetamine adolescent, the L.S.D. boys and the serious hard drug addict is not yet very convincing. Chein reviewed a series of heroin addicts in New York and found that 86 per cent of them had previously taken cannabis, but could not number the weed smokers who had gone no further: this gap may always provide difficulty. It remains that dependence amounting to serious addiction bears a close relationship to "deliquent sub-culture", and poverty, if anything, seems to encourage both.

The Law

Three basic laws are in current force, and their efficiency in controlling the spread of drug traffic lies largely in the hands of the doctors—registered medical practitioners—who issue them. It was—and still is—the indiscriminate, almost wholesale, prescribing of barbiturates, ureides and carbamides—and nowadays of the tranquillisers—that has caused the alarming rise in both accidental and suicidal poisoning by these hypnotic drugs. They have become a universal *placebo* for everything from anxiety to attrition, insomnia to mere incompetence.

Statutory Provisions for Control of Drugs

The penalties that may be imposed vary from a £50 maximum fine for taking liberties with the Ph. and P. Act to £1,000 fine and/or ten years for D.D.A. abuse—and, though not yet fully exploited, unlimited fine and/or two years for offences under the 1964 D. (P. and M.) Act.

Table 2.

	STATUTORY PROVISIONS FOR CONTROL OF DRUGS		
	Dangerous Drugs Act (1965) and Dangerous Drugs (No. 2) Regulations (1964)	Drugs (Prevention of Misuse) Act 1964	Pharmacy and Poisons Act 1933, Poisons List Order 1966, and Poisons Rules 1966
Drugs controlled	Opiates: Morphine Heroin Methadone Synthetics: Analgesics Pethidine, etc. Cocaine Cannabis	Amphetamines Lysergic acid diethylamide (L.S.D. 25) and mescaline etc.	Barbiturates, carbamides, ureides, glutarimides, etc. Many other substances are controlled under these provisions.
Main provisions	(a) Offence to possess without authority.	(a) Offence to possess without authority.	(a) No offence to possess without authority, but substances in Schedule IV may be sold only by an "authorised seller" on a prescription from a practitioner.
	(b) To be kept under lock and key by authorised persons.	(b) Need not be kept under lock and key.	(b) Need not be kept under lock and key.
	(c) Authorised persons have to keep records of drug movements.	(c) Authorised persons need not keep records of drug movements.	(c) No records except private prescriptions, to be copied in prescription book.
	(d) Offence to import and export except under licence.	(d) Offence to import except under licence.	(d) No restriction on import or export.

To these enactments must now be added the provisions of the Dangerous Drugs Bill of 1967, enforcing the notification of addicts to hard drugs by doctors setting up diagnostic "panels" and providing special treatment centres for those who ask for treatment. How do these regulations work in practice? Should Courts of Law or the G.M.C. deal with loose prescribing or failure to notify? Will doctors ever submit to restrictions on their freedom to supply anything from dexedrine to diamorphine? Can C.M.B. nurses be deprived of that powerful pain killer pethidine? Did not the power to withdraw authority to issue D.D.A. preparations already stifle the qualified peddler and doctor addict effectively enough? And what, apart from the offence of actual "possession", might detach the "unwashed" adolescent from dependence on the other drugs: it's one thing to know they're at it and another to catch them with it.

There is nothing *in law* to prevent a doctor from ordering or providing any—literally *any* quantity of a "dependence" drug. In 1962, *one doctor alone* prescribed almost 600,000 tablets of heroin "for addicts". I have seen hundreds of pills, capsules, tablets lying in profusion around the house—and a new prescription for a hard drug (or even two from different doctors) "at the ready". No one ever collects the left-overs and thousands of expensive, hypnotic and tranquillising capsules and tablets go down the "loo" weekly in every Coroner's Court. Prescriptions are necessary, yes, but even for the hard drugs, morphine, heroin, methadone, pethidine, there is no long arm to restrain the doctor—other than the occasional snooper from the Home Office who may wish to see the books. Doctors themselves (probably about 1 per cent) may fall a prey to their own drugs—I have had a coloured musician addict who obtained heroin from three doctors, two of whom were, themselves, addicts, and the jazz man kept himself better off by peddling what he didn't need.

Could the prescription of the hard drugs be limited to selected doctors? Outcry from the others. Could addicts be made to attend treatment centres of the Brain Committee type? It will be tried under provisions of the 1967 Dangerous Drugs Bill enactments: but the scheme, unlike that in the States, is voluntary—never a rewarding basis for addicts. And what about those dependent on the "softer" drugs?

The Future

The rate of increase in drug taking among adolescents (*vide* Table 1), in particular of cannabis, amphetamines, lysergic acid diethylamide (L.S.D.) heroin and cocaine has so alarmed the Home Office that it has urged the Police to strong action under the Drugs (Prevention of Misuse) Act 1964, and the Dangerous Drugs Act. "*Possession without authority*" is all that has to be proved, and a fine of as much as £200 and/or six months jail can be imposed summarily—without the fuss of indictment: the latter can be kept for the "big boys" in the business. D.D.A. offences must be dealt with firmly in the right quarters: it is the smuggler, the pedlar and the shark doctor who are most to blame, and they can get £1,000 and/or ten years: money is not scarce among them and the penalties must hurt to discourage "les autres".

The patient is in a different category, for he is likely, with the hard synthetics, to have developed such an utter physical dependence on an increasing dosage that his craving has wrecked him morally and physically. "Addicts" are more likely to be temporarily restrained by medical and psychiatric treatment than cured. The hope that "Brain" Centres of care and treatment, such as Guy's has set up, and the "Research" encouraged, will shoot down this bogey is a thin hope—but they must be tried.

KEITH SIMPSON

MICROBIOLOGY AT GUY'S

by

R. Knox

(Department of Bacteriology)

Despite the advances made in recent years in the prevention and treatment of bacterial and viral diseases, many fundamental questions are still unanswered. What really determines the virulence of micro-organisms? What makes them suddenly capable of spreading through a community in epidemic form? What is the difference between toxicity and virulence? What is the mode of action of chemotherapeutic drugs and antibiotics on bacteria and how can these be rationally used? How does resistance to these drugs arise in bacteria and how can its development be prevented? To find answers to these and similar problems is clearly of the greatest importance for clinical and preventive medicine and not just an academic exercise. Yet many of these problems are of such a nature that the answer, if it is to be found at all, will be found only by fundamental study of the biology of micro-organisms as a subject in its own right. This inevitably leads us into biochemical, genetic, immunological and other aspects of micro-organisms at a fundamental level. But however remote and sophisticated these may appear to become, so far as the Department of Bacteriology is concerned their justification is always their relevance to infectious disease in man, its control and prevention.

Mode of action of penicillins and the development of drug resistance.

(R. Knox, J. T. Smith, and J. M. T. Hamilton-Miller.)

For some years the mode of action of penicillins (especially of the new semi-synthetic penicillins) has been under investigation in this laboratory. Attention was concentrated at first on the action of methicillin and cloxacillin on staphylococci, on the stability of these antibiotics to penicillinase, and on their ability to induce staphylococci to form increased amounts of penicillinase. In addition, Mrs. Poston investigated the transduction of penicillinase and resistance to streptomycin and tetracycline by means of bacteriophage.

More recently attention has been concentrated on Gram-negative coliform organisms with special emphasis on ampicillin, on the permeability of bacterial cells to penicillins, on synergistic combinations of penicillins and on the relation between intrinsic resistance to penicillins and their destruction by penicillinase.

Characterization of different penicillinases. (J. T. Smith, J. M. T. Hamilton-Miller, and R. Knox.)

The destruction of penicillins by penicillinases from different species of bacteria, particularly Gram-negative, has been studied. In the past most workers have assumed that all penicillinases, irrespective of the organism producing them, would be similar. However, the findings at Guy's have revealed that, generally speaking, this is not the case and each species makes a specific enzyme which can be identified by several biochemical criteria. Several interesting facts have emerged especially regarding the penicillin resistance of these penicillinase-producing bacteria. For example, many workers assume that all penicillinase-producing bacteria will be resistant to ampicillin since penicillinases previously studied hydrolyse ampicillin more rapidly than benzylpenicillin. However, it has been found that *E. coli* penicillinaise does not hydrolyse ampicillin at all and thus such strains cannot be resistant due to the destruction mechanism. This is perhaps an over-simplification since there is no doubt that penicillinase-producing *E. coli* are somewhat more resistant to ampicillin than strains lacking penicillinase and work is being done to investigate this point.

Other findings have been concerned with the control of penicillinase synthesis. Generally speaking the penicillinases of Gram-positive bacteria, *Proteus* and *Pseudomonas* are inducible whereas the penicillinases of other members of the enterobacteriaceæ are constitutive. This means in practical terms that when the former come into contact with penicillin they produce more enzyme and can destroy and resist high penicillin concentrations whereas the latter produce the same level of enzyme irrespective of the presence of penicillins. Studies are being made to investigate further these control mechanisms acting on penicillinase synthesis.

Resistance transfer factors (R-factors). (J. T. Smith.)

These are extrachromosomal elements which carry hereditable information between different bacterial strains and species. A bacterium possessing an R-factor can be resistant to one or several antibiotics and donate these resistances to previously sensitive organisms which are then also able to transfer the resistance. Antibiotics to which this applies are streptomycin, kanamycin, neomycin, tetracycline, chloramphenicol, sulphonamide and penicillin. At Guy's these agents are being investigated along several lines. The ability of different strains and species to act as donor or recipient has been investigated and it has been found that the two abilities are not linked in that strain B may act as a good recipient for strain A but when B possesses the R-factor and A does not the transfer rate is much reduced in this direction. Some strains have proved exceptionally good recipients but fail to donate the R-factor. This has been investigated and it has been found that special conditions can result in transfer from these previously refractory strains.

Penicillin resistance as carried by R-factors can be of the penicillinase type and R-factors have been studied in the department to investigate what happens when, for example, a Klebsiella type penicillinase is put in other species of bacteria. By these means strains have been constructed possessing two types of penicillinase, (1) their "own" chromosomal penicillinase and (2) a penicillinase specified by an R-factor.

Biochemical studies of R-factor penicillinases. (J. Dale.)

J. Dale is investigating the biochemistry of these strains to determine whether the R-factor can produce the same enzyme protein irrespective of the species and to date purification of these enzymes in a limited number of species has tended to suggest that the enzyme is, in fact, similar for any one R-factor. Further work along these lines is being done to investigate the control of R-factor penicillinase in many different species and to date it has been found that most species are in fact similar in this respect.

Steam sterilization. (R. Knox and J. K. Pickerill.)

Work has continued on methods for the detection and removal of air from porous loads in high pressure steam sterilizers. The presence of air in such loads either because of inadequate removal from or leakage into the autoclave, is the chief cause of failures in sterilization, and the problems it creates are of considerable interest as well as being of practical importance. Methods are being devised for improving the reliability of air-detecting monitoring devices and for more rapid and efficient methods of air removal.

Pyelonephritis. (Dolores Furtado, R. H. Gorrill.)

Little is known about the natural history of pyelonephritis as is shown by the number of patients first found in terminal failure, hypertension or at autopsy. We have spent some years in devising models of the disease which allow us to follow the infection bacteriologically and histologically.

With the establishment of successful experimental infection we are now studying the problems of treatment. Dr. D. Furtado, working on an N.I.H. Grant, has used colistin to treat *Pseudomonas aeruginosa* infection. We find that pre-treatment would not prevent disease, while treatment around the time of infection would. As time went by the ability to prevent the disease waned and at three days the drug had little effect. This type of study is promising to help us understand the clinical problems of chemotherapy.

Staphylococcal virulence. (R. H. Gorrill, Evelyn McNeil.)

Despite the numerous toxic products associated with staphylococci the nature of their virulence is obscure. We have in this department recently come across examples of variation in virulence in experimental infection which we thought were due to the amount of clumping factor present (the modern term for the substance

responsible for the slide coagulase test). Further research has convinced us that there must be another unknown surface antigen present responsible for the effect. With this knowledge we have examined a number of clinical strains and been able to isolate three which possess this new antigen. The way in which it affects virulence is under investigation.

We have recently expanded into dental bacteriology with J. M. A. Wilton joining the department and he has started investigations into several different facets of this complex field.

Experimental oral infections. (J. M. A. Wilton.)

The participation of the indigenous oral flora in the pathogenesis of human periodontal disease is universally acknowledged. The exact part played by the oral flora in general systemic disease is not well understood but present immunological knowledge in the field of autoimmunity indicates a possible mechanism for the action of the oral flora. Using laboratory animals and human oral organisms, the relationship of focal oral infection (focal sepsis) to changes in the general immune system is being studied. This work is supported by the Nuffield Trust.

Role of delayed hypersensitivity in oral Candidosis. (J. M. A. Wilton in collaboration with J. C. Davenport, University of Birmingham.)

Intestinal Candidosis has been shown in a number of instances to have an allergic component. In this study an attempt is being made, using immunological methods, to see if Candidal infections of the mouth have an allergic component.

Immunological cross reactivity of oral microorganisms and oral tissues. (J. M. A. Wilton in collaboration with T. Lehner, Department of Dental Medicine at Guy's.)

In this study, the relationship between the antigen of oral tissues and various oral bacteria is being investigated. Certain types of oral ulceration have an autoimmune basis and this work may indicate further mechanisms in the aetiology of certain oral diseases.

Serological classification of mycobacteria. (J. L. Stanford in collaboration with A. Beck, of Paddington General Hospital.)

As more and more cases of human disease due to mycobacteria other than *Myco. tuberculosis* or *Myco. Leprae* are being reported, the accurate classification of the genus has become of considerable interest. A serological classification and scheme of antigenic interrelationships for a number of species has been elaborated and further work is in progress.

An analysis of Mycobacterium avium. (J. L. Stanford in collaboration with R. Muser, of the Tierhygienisches Institut in Heidelberg.)

A large number of strains of this very complicated "species" isolated from both man and animals in Britain and West Germany are being investigated by numerous methods. It is hoped that the results obtained will help to elucidate the relationships between the causative organisms of human and animal "avian type tuberculosis".

This account has given an outline of the main research activities of the Department of Bacteriology. But it has other activities and interests too. It is responsible for the teaching of microbiology to medical and dental students and it is available for consultation (and frequently is consulted) on problems in clinical bacteriology arising in hospital patients, though not responsible for routine examination of clinical specimens. Partly because of its remote geographical situation, perched rather inaccessibly on the 5th floor of the Medical School and with an erratic lift service, partly for other reasons, there is a danger of the Department becoming, or appearing to become too remote and detached, both in its teaching and in its clinical contacts. But the members of the Department are well aware of this and are ready to help in any way they can in all aspects of the work in the Department, whether in research, in teaching or in clinical bacteriology. In the teaching of medical students there is no doubt that the informal tutorials given to small groups of student in their second clinical year, together with the increasing scale of microbiological demonstrations arranged for students throughout the clinical period, are helping to remind them of the clinical and epidemiological importance of microbiology. There is also no doubt that the teaching of microbiology at Guy's suffers from the timing of the main course which comes during the Introductory Clinical Period, before students have had a chance to appreciate the clinical importance of the subject. But the tutorials and demonstrations do help to overcome this disadvantage and to increase understanding of microbiology among clinical students, and in addition give them some idea of the kind of microbiology they will be expected to know when they come to take Pathology in their Final Examination. There is another aspect of the teaching of microbiology which should be mentioned. London University is now making considerable changes in the structure of its courses for the B.Sc. Degree and a number of Medical Schools are including, or shortly will be including, Microbiology as a part of such courses, in combination with other course units in subjects such as Immunology, Genetics, General Pathology, etc., as well as "orthodox" preclinical subjects. The Department of Bacteriology at St. Mary's is having such a course and the Department of Bacteriology at Guy's is planning to co-operate in parts of it. This is another way in which it is hoped to extend the range of subjects which students can take for a B.Sc., so as to include "para-clinical" as well as "pre-clinical" subjects and so broaden the base on which their clinical studies will be founded. Microbiology is a useful subject from this point of view, combining as it does academic interest as a branch of biology in fields such as virology, immunology, bacterial metabolism and microbial genetics and clinical and epidemiological interest in fields such as chemotherapy, drug resistance and immunity in the individual and in the community. The Department of Bacteriology is interested in all these things.

WILLS LIBRARY ANTIQUITIES

10. JAMES PARKINSON — SURGEON GEOLOGIST AND REVOLUTIONARY

by William Hill

James Parkinson is best known for his *Essay on the Shaking Palsy* in which he described the condition which bears his name. He was also the author of several other medical and scientific works as well as a series of revolutionary pamphlets. He was a practitioner in Hoxton who had studied for a while with John Hunter. Apart from this, we know nothing of his early life. The first mention of him is in 1785 when he was known to be in practice.

The French Revolution encouraged the formation in England of clubs and societies dedicated to social and political reform. Among these were the Society for Constitutional Information and the London Corresponding Society. Parkinson was a member of the latter, and in 1794 was examined by the Privy Council when they were investigating the "Pop-gun" plot. This was an attempt on the life of George III by shooting at him with a poisoned dart. Parkinson appears to have been innocent of any part in the plot and although some of his friends were arrested and tried he remained at liberty.

During the years 1793 and 1794 a series of pamphlets appeared in the bookshops signed "Old Hubert". These are now known to have been the work of Parkinson. Among them were *An account of some peculiar manners and customs of the people of Bull Land* and the *Knaves Acre Association.* He had an intense dislike of Edmund Burke and several pamphlets were directed against him. Parkinson was particularly angered at Burke's remarks about "learning being trodden under the hoofs of a swinish multitude". His reply was *An address to the Hon. Edmund Burke from the swinish multitude* and concluded with—

"Let us then be all esteemed as swine together; we will be satisfied with the plain appellation of the *swinish multitude*, whilst you and your friends who are so fond of distinction, shall be termed HOGS OF QUALITY; nor shall we grudge you the high-sounding titles of Right Reverend most noble and puissant, most honorable gracious and illustrious, high and mighty Christian and catholic swine."

A later pamphlet *Pearls cast before Swine by Edmund Burke—scraped together by Old Hubert* was much more serious and less abusive.

Among his other works were *The chemical pocket-book* (1799), *The Hospital Pupil* (1800), and *Medical admonition addressed to families respecting the practice of medicine* (1799). *The hospital pupil* was a short essay on medical education addressed to the father of a prospective medical student. In it he stresses the necessity for a careful choice of students because of the high qualities required; he attacks the requirement of a seven-year apprenticeship of which one year only was spent in hospitals as being a waste of time. He suggests that more time be spent in hospital and less on such skills as dispensing which occupied much of the early years of medical education. Among his remarks on the profession is the warning to the student and his parent—

"Let him then reflect on the miserable course of life he had destined his son to pursue. He arrives, perhaps with unremitting ardour to benefit those who call on him for aid; but from frequency of failure, he at last takes alarm, revises what is past, and judges it by the knowledge which daily experience brings him. His mind is perpetually stung by self-accusations. He perceives that, in spite of his utmost exertions, these calamities increase which it is his duty, and his most anxious wish, to diminish; and, with pain, he discovers that his endeavours are too frequently, not only unsuccessful, but even injurious. Can it be a matter of surprise then that he often finds himself agitated with most distressful doubts, as to the mode of conduct to be adopted, when a valuable life is at stake; and that he loads himself with reproaches for having perhaps, augmented through ignorance, those calamities which a man of more information might have entirely removed."

He was also concerned with the fact that

" . . . physicians are sometimes called in too late, and for the purpose too often of according a sanction to what has passed; that a stranger to the modes of the country might think that their office was rather to administer extreme unction than relief to the sick."

He returned to this theme in his *Medical admonition addressed to families*—"Convinced that many lives are lost by neglecting to apply sufficiently soon for medical aid, and by improper treatment of diseases by domestic practitioners, the writer of the following observations offers them to the public, with the pleasing hope that they may lessen the number of victims to negligence and presumption."

For some years Parkinson devoted a part of each day to his hobby, geology, and the fruit of this was seen in 1804 when he published a three-volume work *Organic remains of a former world*, which has been considered a landmark in palaeontology.

A good account of Parkinson and his varied interests is to be found in the bicentenary volume edited by Macdonald Critchley and issued in 1955. This contains a good biography as well as a reprint of the *Essay on the Shaking Palsy*.

MUSIC

CHRISTMAS CONCERT

Guy's Christmas Concert, in Southwark Cathedral on December 7th, promises to be a real musical event. Starting with some Baroque Brass music (it seems that no Guy's concert would be complete without some 16th or 17th century Italian music), the first half is completed by the 2nd Piano Concerto of Beethoven. This work was written in 1795 and first performed by the composer in Vienna as part of a series of subscription concerts in 1799. It was, in fact, the first concerto written (but published second). It bears more than fleeting traces of its Mozartian ancestry, but is notable for a superb slow movement and a bucolic finale (here Haydn is in evidence).

The second half will show just how much progress the Guy's Hospital Chorus has made under Steven Coles' persuasive direction. Ambitiously, they have met with popular request and are indeed performing a Haydn Mass—arguably his greatest work: the "Nelson" Mass. Four soloists have been invited to join the choir and Mr. Coles is apparently using the woodwind version of the Mass rather than the old (and original autographed) organ version (with full strings, of course). This Mass is in the standard form but for those who might not know it, the programme will provide he "words" and a full translation. A notable feature of the Mass is its use of three trumpets—particularly in the Benedictus, which was apparently added when Haydn heard of Nelson's victory in 1798.

I can only add that I hope the hard work of the chorus and orchestra, not to mention Stephen Coles, will be rewarded by a full house.

NEW MOZART RECORDS

Recently the record companies have decided (so it seems) that Mozart's orchestral music is unrepresented on record. E.M.I., using their brilliant new Pianist/Conductor, Daniel Barenboim, with the English Chamber Orchestra, have embarked on the complete symphonies(!) and piano concertos. The first symphony record offers The Haffner and Prague (35 and 38) as well as No. 32. Barenboim takes fast movements very fast (particularly the last movement of the Haffner) and slow movements very slowly. The overall effect is of infectious gaiety and as the (stereo only) recording is outstanding, I must recommend it. I'm less happy about the piano concerto record (No. 20 in D minor and No. 23 in A major): the characteristics are the same, but the clarity of finger work cannot compare with Kempff in No. 23; in No. 20 his speed changes are somewhat eccentric also.

Leonard Bernstein, whilst in Vienna in Spring 1966, recorded Verdi, Mahler and Mozart in his record of the Linz Symphony No. 36 and Piano Concerto No. 15 in B flat, conveys the rapport that was rapidly established between conductor and orchestra. One could criticise Bernstein for tempo-juggling—listen to the end of the Linz last movement or the overall gain in speed in the concerto slow movement; but the record is still so enjoyable that these mean little. This is an excellent Decca recording.

HEDLEY BERRY

CORRESPONDENCE

Astley Cooper and Osler

SIR,—The most recent of the interesting articles by Mr. Hill on the Wills Library Antiquities refers to the connections of Sir William Osler with the Library. He does not mention an unusually interesting and valuable document that used to hang framed in the Library but was nearly lost as a result of storage during the danger period of the last war.

When I was writing about Astley Cooper's contribution to arterial surgery, I remembered this document, which was an account written by a Guy's student who was present when Astley Cooper ligated the abdominal aorta for an iliac aneurysm on July 5th, 1817. I could well remember the description of the dramatic moment when Cooper said "Gentlemen, I have the pleasure of informing you that the aorta is now hooked upon my finger."

When I inquired in the Library for this document I was met with vigorous denial of its ever existing. However, insistence on searching led to its discovery, hidden in a cupboard, faded and unprotected because it had been taken from its frame. It was a letter written by a student named Edward Osler and it was presented to Guy's Hospital in 1917 by his nephew Sir William Osler, just one hundred years after the operation. An account of the document is in the Guy's Hospital *Gazette* for 1911, volume 25, page 277.

The letter was taken over for safe keeping by the Department of Surgery.

It would seem that now, 150 years after the occasion and some 50 years after Osler's gift, its existence is largely forgotten, hence my letter to you.

Yours, etc.,

BROCK

Guy's Hospital,
London, S.E.1.

Compassion Impassioned on Nursing

SIR,—It would be interesting to know for whom the writer of this article speaks. If they are views of an individual, they will be received with due reservation and attract the notice they merit. It is a pity that such an article is written for a journal with a world-wide circulation and open to the general press. It can give no help to the medical and nursing professions, least of all to students embarking on a difficult career or, through them to the patients.

I cannot believe that nurses have changed so fundamentally in a decade. Before this, I worked with them closely for around fifty years. Nurses have never sought a pedestal. Could it be that they have earned it? There is little constructive thinking and less feeling in the article. This combination usually stems from frustration; so maybe it is the writer who needs our compassion.

Realizing my limitations, I will not attempt to defend the Church and her ministers, but it can be only ignorance that prompts the writer to pick on a relatively small part of their ministry "sermonizing". Any rate, we have the Sermon on the Mount to support us. Space does not permit me to question the very shallow thoughts expressed on Death, so I will conclude with a quotation from Sir Thomas Browne's *Religio Medici*: "I boast nothing, but plainly say, we all labour against our own cure; for death is the cure of all diseases. There is no universal remedy I know, but this; which though nauseous to queasie stomachs, yet to prepared appetites is Nectar and a pleasant potion of immortality."

Yours, etc.,

FLORENCE TAYLOR

Flat 2,
103, Blackheath Park,
S.E.3.

Missing Books

SIR,—Mr. Budden complains that modern books in the dental section are "just never there". He has raised an important issue, and we feel these facts should be placed on record.

The Wills Library purchases a good number of new dental books and new editions as they are issued. These are placed on the shelves within a few days of purchase. Within a short time a high proportion of these are borrowed anonymously, never to return.

The suggestion that books should be chained to the shelves has been tried in the form of locking cases. Some months ago the cases containing the dental periodicals were locked and opened only on request. Within a couple of days the cases were burst open. Eigh consecutive issues of the British Dental Journal vanished from the periodical rack within a few hours of being placed there. We now issue this only on demand. We also have a case of essential reference books kept locked. Within the past ten days three expensive reference books have been removed without trace.

We lose medical as well as dental books. The loss of dental books is perhaps more evident as there are fewer titles at risk, but certainly the losses are very much higher in the dental section.

The problem is very much on the minds of the library staff, and there are frequent discussions as to how we can stop this anti-social behaviour. We welcome suggestions which may help us to overcome the difficulty. We can also assure Mr. Budden that book losses are deplored by the staff as much as by the readers.

Yours, etc.,

WILLIAM HILL,
Wills Librarian
ROBERT KNOX,
Hon. Wills Librarian

The Wills Library,
Guy's Hospital,
London Bridge, S.E.1.

Disproportionate Players

SIR,—The recent correspondence about H.O.P and especially Mr. H. C. Sharp's letter, has stimulated me into writing.

A few years ago, I was invalved in some corresposdence in your columns, at a time when the Rugby Union Committee was deliberating the wisdom or otherwise of weakening the First XV fixture list. Amongst other remarks, I criticised the niggardly way in which the match reports were presented in the *Gazette*. What was true then, is still more apt today, now that the First XV is fast regaining the prestige of former years.

I suppose it is in the cause of economy that the very well-written reports are presented in such a microscopic manner, even omitting, as often as not, the names of the team at the end of the account. This is curiously discouraging treatment for a side which has to be congratulated upon hitting the headlines in this week's *Daily Telegraph*. And yet, in the same issues, a whole page, in quite legible print, can be devoted to some musical personality or another, whom we all revere, but who has not, as far as I am aware, the slightest connection with Guy's.

I think the *Gazette* has got its values a bit wrong. It should be realised that there are quite a number of us who, when we read of the doings of the Guy's Hospital Rugby XV, get almost as much excitement as when we read Passim, and it would be nice to be able to do so with a similar degree of comfort.

Yours, etc.,

OLIVER IVE

121, Harley Street,
W.1.

The College and T.B.

SIR,—Dear, dear Mr. Dominick! you worry me in as much as you appear to be unaware that *adequate rest, good food properly served,* and recreation inclusive of fresh air, are conducive to good health.

Perhaps you were a Dental H.S. not called upon to work night and day, and alas! your diagnosis is greatly at fault in assuming that I am young and unthoughtful. With a personal knowledge of many who suffered ill-health and even died (as stated in my last letter, House Officers were in contact with many infections not necessarily T.B.), my observations covered thirty-one years. My letter was concerned with possible ways by which "Englishmen" might become ill.

You have not convinced that conditions of work, and the living conditions provided in the College could not have been improved had they not been accepted as normal by those who authorised them—or that a more humane and improved routine and condition of living could not have been introduced, in spite of lack of money, by more forethought and realistic administration; the long term view from those days could have their repercussions today.

As the care of the sick had its inception in Religious Houses, have we not progressed beyond that of Monks who went about with peas in their shoes for the good of their souls!

Some traditions take a lot of killing, let us cast out as anachronisms those which are bad in principle—proper care of those who work in hospitals is a good principle both now and for the future.

Dear Mr. Dominick, please remember all those medical "Englishmen" who emigrate (one likes to think it is not entirely L.S.D. which impells them to go) or that Provincial Hospitals would close their doors without the foreign staff they now employ.

As to Englishmen at sea, I must confess that my information only covers dripping walls—I had no idea the dear old College was afloat—live and learn!

Yours, etc.,

Senior Citizen M. S GRIFFITH

"Moonrakers",
Mawgan Porth,
N. Cornwall.

NOTICES

GUY'S HOSPITAL NURSES' LEAGUE
SIR COSMO AND LADY MABEL BONSOR SCHOLARSHIP

£200 is available for Members of the League to undertake Post-Registration Study at home and abroad. Applications giving details of the Study to be undertaken, should be sent to the Matron and Hon. Secretary, Guy's Hospital Nurses' League, Guy's Hospital, London, S.E.1, by the 31st January, 1968.

NURSING SECTION

UNIFORM CHANGES

Due to the change in the length of training at Guy's from four years to three years and three months, it has become necessary for nurses to take more responsibility at an earlier stage in their training. In most cases this has been shown to be entirely justified and the nurses themselves have proved capable, and have welcomed this.

After much discussion a decision has been taken to change the methods of symbolic promotion of the nurses and the standards that they must achieve for each stage.

The uniform changes are thus:—

Introductory Course nurses wear the same uniform dress and apron and a cap with a purple band around the edge. They retain this purple band during their first month on their first wards. Following this they wear the same uniform as the present first year nurses.

After one year the nurses's Tutor will decide whether sufficient use has been made of the ward experience. The award of a lilac belt will depend on this decision, in addition to the confirmation from the Ward Sisters' reports that the individual student nurse has achieved a standard which deserves her further promotion.

During her second year the student nurse works mainly on special wards and departments to gain the required experience for the standards of the General Nursing Council. From this stage nurses will retain the lilac belt until qualification.

For the award of the additional "Strings" nurses will no longer be required to complete their Records of Practical Work after two years and three months. "Strings" will now be given before this record is complete, and in future the nurse must complete her Record by the time she is ready to send in an entry form for the Final State Examination.

These changes should be of great value to the nurses, because no longer will it be necessary to be kept back from promotion due to the fact that a nurse has never seen or carried out a certain procedure. Possibly the present "Strings" who are back on the wards after their year's special experience see far more procedures than they ever did as junior nurses, and will thus gain experience and satisfaction and also stability in their ascension of the "Nursing Ladder".

The passing of the "Stripes" will doubtless go unmourned. They were never neat looking and the satisfaction a nurse had from wearing them was when she was first presented with them.

Now we will need a new name for the 2nd year nurses . . . Lilac Belts? or "2nd Year's"? By the way, does anyone know why "Stripes" ever came into being?

It is regretted that the name of Mr. D. C. Cobell was omitted as the author of the article entitled "Our Compassion" in the Nursing Section of the issue November 11th.

STAFF CHANGES AND APPOINTMENTS

NEW APPOINTMENTS

Sister E. Ferguson to Caleb/Diplock, Night Duty

Sister S. Smith to Recovery Unit.

Sister R. Hungerford to Theatres.

C/N. W. Howell to I/C Queen Ward pro tem.

Sister P. Lawrence to Administrative Sister, Matron's Office.

Sister S. Price to Assistant Matron, Matron's Office.

DEPARTURES

Sister K. Davies from Salomons Centre.

SPORT

U.H. CENTENARY

U.H. v. PRESIDENT'S XV

Crystal Palace National Recreation Centre Wednesday, 15th November, 1967

The President's XV contained four internationals in H. C. Burry (New Zealand), V. Harding, B. G. Sherriff, and W. T. Treadwell (England); three triallists in R. B. Hiller, H. Keith, and P. Thorne; and two current Guy's players due to last minute withdrawals. The usual late changes in the Hospitals' side allowed room for 10 Guy's players.

As could be predicted, the sides lacked cohesion and the game was rather scrappy. But both sides attempted to play the open football expected by the very small crowd hiding away in the recesses of the huge and impressive stadium.

The heavy President's pack played with determination and gained much good ball. Consequently, most of the play took place deep in the U.H. half and the hospitals were forced into desperate defence, using only seven forwards—the full-back having been injured in the early interchanges.

Eventually the President won with tries by H. Keith and D. Biggs, and with a conversion and penalty by R. B. Hiller. J. Ross scored two tries for U.H. to make the score 11 points to 6.

The Dinner afterwards, in the adjacent restaurant, proved to be a great success. Excellent food and wine were followed by witty, interesting and historically informative speeches by W. A. Law, O.B.E., F.R.C.S. (ex-President of U.H.), T. L. T. Lewis, F.R.C.S., F.R.C.O.G. (President) and Mr. Robin Marlar (of the *Sunday Times*).

RUGBY

This season Guy's regained a fixture against Wasps. A 6—3 victory was well deserved, and Rupert Cherry (*Telegraph*) could not have paid them greater tribute than to compare their style of play to that of the New Zealanders. They harassed the Wasps into mistakes and prevented them from developing any set moves. However, two good tackles by Elliott did destroy what seemed to be "certain" tries. Elliott kicked a penalty goal, but Wasps were soon to reply in the second half. Peace provided Guy's with an unconverted try to win the match. However, it was felt throughout the game that Guy's had command and indeed they should have scored more points and had ample opportunity to do so.

C. Thorburn was selected to play for Stanley's XV against the Varsity.

U.H. JUDO

In yet another sport, Guy's helped to beat Cambridge University. John Wood (Guy's Fresher) produced one of the highlights of the competition by using a classical tsurikomi-ashi in the opening seconds of his contest. Clarke (St. Bart's) also produced a win in a similar time by using harai goshi. United Hospitals eventually beat the Varsity 30 points to 20.

SOCCER

The addition of a professional coach and vigorous training sessions in a Dulwich gym have improved the 2nd XI performance this season. On encountering Imperial College, they had a formidable task of erasing last year's heavy defeat. However, their confidence overwhelmed their opponents and Guy's won 2—1. St. Mary's College were even easier opponents and Ward-Davies, scoring well for Guy's, helped Guy's to a 6—0 win. The Guy's 2nd XI defence seems fairly sound, but if the forwards were to show more penetration in the first half they would be winning by even greater margins.

BLUES

The following Blues were awarded on November 1st.

RUGBY FOOTBALL

P. Swift	... ...	Full Blue
M. Cockburn	... ...	Full Blue
D. Elliott	... ...	Full Blue
G. Hey	... ...	Full Blue
R. Beacham	... ...	Half Blue
J. Price	... ...	Half Blue
D. Curson	... ...	Half Blue
C. Neville	... ...	Half Blue
C. Pearson	... ...	Half Blue
R. Kendrick	... ...	Half Blue

ASSOCIATION FOOTBALL

I. Nash	... ...	Full Blue
D. Lindridge	... ...	Half Blue
R. Lovell	... ...	Half Blue
R. Davey	... ...	Half Blue

HOCKEY

J. Crafts	... ...	Full Blue
S. Cripps	... ...	Half Blue

BOAT CLUB

A. Hodgkinson	...	Full Blue
G. Stygall	... ...	Half Blue
T. Kirk	... ...	Half Blue
J. Skuse	... ...	Half Blue

SQUASH

J. R. Webb	... ...	Full Blue
E. P. Davies	... ...	Full Blue

GOLF

P. Ellis	... ...	Full Blue
D. Elliott	... ...	Half Blue
N. Curry	... ...	Half Blue

BOXING

S. Marsh	... ...	Half Blue

DIARY

RUGBY

Nov. 25. Cheltenham—Cheltenham.
,, 29. Loughborough Colleges—Loughborough.
Dec. 2. Streatham-Croydon—Thornton Heath.
,, 9. Old Cranleighans—Thames Ditton.

HOCKEY

Nov. 25. Surbiton 2nd XI. A.
Dec. 2. Merton. A.
,, 9. Bexleyheath. H.

SOCCER

Nov. 25.† Woolwich. H.
,, 29.* R.D.H. A.
Dec. 2. U.L. Cup, Round 1.
,, 6.* Charing Cross Hospital. A.

*Denotes United Hospitals' League fixture.
†Denotes University League fixture.

RUGBY

GUY'S v. BEDFORD

At Bedford Saturday, 21st October, 1967

Result: won 8—0

The Hospital's side showed one change from the team that had beaten Cambridge University on the previous Saturday. M. Cockburn is away in Kenya until Christmas, so C. Neville moved into the 2nd row from No. 8. The vacant back-row position was filled by M Forbes, who played for Cambridge U. LX Club last season. The Bedford side included Rogers, the England wing-forward, who recently returned from Canada.

Rain throughout the morning had made the surface of the pitch slippery, and the ball was difficult to handle. Guy's, playing up the slope in the first half, soon showed themselves to have the better pack, and Swift kept them going forward with sensible use of the touch-line and kicks into the box Neville and Peace dominated the line-outs and the back-row looked dangerous with the ball at their feet. Bedford showed a reluctance to drop on the ball—even Rogers made the fundamental error, in the conditions, of trying to pick the ball up on the run—and it was usually left to Jack Smith at full-back to repel the danger. His excellent all-round play and lengthy touch-kicking were notable features of the game and on numerous occasions he returned poorly directed touch-kicks and diagonals with interest. Eventually, Guy's pressure brought reward. From a scrum 10 yards from the Bedford line, Rowlands and Novak executed a perfect scissors on the blind-side, for the latter to score a try, which Elliott converted. Soon after, a Guy's passing movement from left to right on the Bedford "25" broke down in the centre, but Rowlands recovered the ball and made ground down the right hand touch-line before kicking high towards the posts. Rogers, in attempting to make a mark, dropped the ball, and the Guy's pack smuggled it away to Novak on the left, who ran strongly to send in Neville (C.) for a try in the corner.

THE MEDICAL PROTECTION SOCIETY

FOUNDED 1892

MEMBERSHIP EXCEEDS 45000

Membership secures protection of professional interests by a personal advisory service and the provision of unlimited indemnity against legal costs and damages.

Apply:—

THE MEDICAL PROTECTION SOCIETY
50 HALLAM STREET · LONDON · W.1
Telephone LANGHAM 9241

Senior Medical Secretary
Herbert Constable
MRCS, LRCP

Dental Secretary
Frank Allott,
LDS

After the interval, Guy's continued to attack spasmodically, but most of the play was between the 10-yard lines. Beacham put in a powerful run down the wing and Thorburn snaked his way through the home defence, but neither effort produced points. Guy's should have scored when Hey was brought down just short of the line. From the ensuing ruck, Peace tried to force his way over on the blind-side, but when held, the ball was quickly fed to the threes. Unfortunately, none of them ran hard or straight to draw the cover defence in, and Beacham was easily stopped in his optimistic canter to the corner flag. In the last quarter, Bedford came more into the game through their stand-off, who found a large hole in Guy's midfield defences. This was due to the wing-forwards committing themselves to the tackle too early in the wet conditions, and also to Rowlands, who failed to go up on his opposite number quickly enough. However, Elliott and the cover defence successfully stifled these attacking thrusts, and the line remained intact, although it usually meant the loss of 40 yards of hard-earned ground. Guy's were content at this stage to sit on their lead, and deservedly ran out victors against a moderate Bedford side which lacked leadership and co-ordination.

HOCKEY

GUY'S v. IMPERIAL COLLEGE

at Harlington. 18th October, 1967

Result: drawn

Guy's were unlucky not to win this hard fought match. The territorial advantage won by Guy's enabled the forwards to put the ball in the net five times; unfortunately only two of the goals were allowed.

The first goal came from a centre from the right which Chase swept into the goal. After this some of the urgency in the Guy's play seemed to fade, leading to the two Imperial College goals. Guy's then took command of the game; the forwards made large gaps in the Imperial College defence and some easy chances were missed. The equaliser came from Goodhart who scored with a fine narrow angle shot from the right.

In the closing minutes the Guy's defence had to work hard to repel some last desperate onslaughts. On the whole the Guy's side played constructive open hockey and began to show more punch in the circle.

Team: C. Calder, M. Vellacot D. Crafts, R. Kendrick, C. Pearson, M. Horrocks, R. Goodhart, I. Cooper, R. Chorse, S. Cripps (Capt.), A. Godfrey.

C.R.P.

UNIVERSITY OF LONDON CUP 1st ROUND

GUY'S v. NORTHERN POLYTECHNIC

Wednesday, 15th November

Result: won 3—1

This is the first year that Guy's have entered this tournament and so the competition was an unknown entity, however, with the knowledge that the cup has been won by hospitals for the past 2 years we approached our first match with a certain amount of confidence.

On taking the field we were confronted with a multi-racial team and rumours ran rife as to how many had actually played for India in the Olympics ! Fortunately our fears were soon allayed as Guy's scored their quickest ever goal. In 30 seconds Appleby won the bully, passed to Cripps who pushed it to Godfrey; the ball then came back in the circle and was pushed home by Appleby.

The play then settled down into quite a hard game and several of their players looked very competent—fortunately they didn't really click as a team. Appleby scored again and at half-time Guy's had the situation well under control. Our defence had the Poly attack so well tamed? that Indian tempers ran a little high and on one occasion resulted in our full back being struck—to Guy's credit this was treated with contempt and hilarity and the assault was one-sided.

The Poly's only goal came from a defensive error which basically was lack of speed to catch up with a breakaway. Cripps netted Guy's 3rd with a sweep shot from a Goodhart centre.

Clark, in goal showed good anticipation and his "taking out" of one of their forwards shows great promise !

Team: R. Clark; M. Vellacott, D. Crafts; R. Kendrick, C. Pearson, V. Harvey; R. Goodhart N. Dodd, M. Appleby, S. Cripps, A. Godfrey.

S. N. Cripps

FOOTBALL

GUY'S v. R.D.H.

U.H. Cup Round 1

Away Saturday, 11th November

Result: won 5—1

Eager to recapture the U.H. Cup which they lost to the London Last season, Guy's were drawn against the weak R.D.H. side in the 1st round.

The opposition could only muster nine players and from the early play it seemed that Guy's could well run up a cricket score. McClure opened the scoring when he easily beat the goalkeeper with an accurately placed shot. Although pressing for most of the first half Guy's were not turning the chances into goals. The visiting side could not settle down properly against an opposition, whose main tactic seemed to be to put the ball out of play a soon as they contacted the ball. Guy's were mounting nine men offensives which resulted in goals by Jacobs, Leeburn and Lindridge, but which also left the Guy's defence wide open for the two man R.D.H. attack to score. Thus, after playing up the slope in the first half Guy's changed round with the score at 4—1.

For the second half Guy's made an interesting tactical move, putting, a certain half-back into the goalkeeper's jersey to allow the half-frozen Wood to thaw out on the field of play. The pattern of the first half continued, but by now R.D.H. had pulled all nine men back to the penalty area. Apart from one goal by McClure, Guy's could find no way through this defensive barrier, mainly because of atrocious shooting and a too selfish attitude of certain players. The time-wasting tactics of the opposition did not help matters and a wholly unsatisfactory game ended with Guy's the winners by five goals to one.

Team: J. Wood, R. Davey, K. Taylor, R. Lovell, S. Watt-Smith, I. Nash, D. Jacobs, I. McClure, D. Lindridge (Capt.), I. Harrison, R. Leeburn.

R. LOVELL

GUY'S v. UNIVERSITY COLLEGE

U.L.L.

Home Wednesday, 15th November

Result: lost 7—2

Reports of Guy's 1st team football this season make monotonous reading. Far too often the story is of the Hospital being just as good as the opposition for about three quarters of the game, and in the remaining quarter giving

the game away by pathetic football, and this game was no exception.

U.C. opened strongly and for the first fifteen minutes the College side was well on top, and deservedly led by two well-taken goals. Both were first time efforts giving Wood no chance, and the second especially was a gem of a goal—hit on the volley from several yards outside the penalty area.

As play progressed Guy's came more into the picture, and had a good deal of the midfield play without really troubling the U.C. goalkeeper. The back line of Davey, Lindridge and Lovell by now seemed to have settled down against the opposition's 4-3-3 formation.

Trailing 2—0 at half-time Guy's scored after 3 minutes of the second half through McClure, who calmly picked his spot, from inside the penalty area. For the next 20 minutes it seemed that Guy's could well be close to picking up their first Premier Division points, but it was not to be. The opposition switch of attacking with 4 or 5 men in a line, completely overran the Guy's defence allowing the opposition to score 3 goals in 4 minutes. The U.C. wingers were given far too much room by the Guy's full backs and with "stopper" Lindridge desperately trying to cover two men at once, Wood was given no chance. A further goal five minutes later and another near the end completed the U.C. scoring. For Guy's Ward, so often the lone ranger in the Rome attack, pulled one back with an opportunist goal.

The lessons to be learnt from this game, is that every player must find his man and stick to him at all times and that 90 minute effort must be given by every player.

Team: J. Wood, R. Davey, R. Lovell, I. McClure, D. Lindridge, E. Elias, D. Jacobs, I. Harrison, D. Ward, M. Taylor, G. Brown.

R. LOVELL

GUY'S v. ST. THOMAS'S HOSPITAL

U.H.L.

At Cobham Wednesday, 18th October, 1967

Result: lost 4—0

Opening their U.H. League programme, Guy's were beaten 4—0 by a St. Thomas's side which can only be described as moderate.

Play began with the Guy's defence slow to settle down, and for the early part of the game there was a fast pace. St. Thomas's took the lead after 10 minutes when Carter failed to hold a simple header from the centre-forward. The Guy's attack was playing better than of late, and they were unlucky not to score on several occasions. However, another defensive slip allowed St. Thomas's to increase their lead, when Carter, the U.H. Captain, shot into an empty net. Just before half-time, the score became 3—0, when lack of covering by the wing-halves allowed the opposition to score.

In the second half Guy's were much more in the game, and were desperately unlucky not to score when a fine effort by McClure was put round the post by the goalkeeper. Despite being awarded a free kick eight yards from the goal line under the new four-step rule, Guy's were unable to find the net. Lack of calling between Carter and Watt-Smith enabled the centre forward from St. Thomas's to score, giving the final result of 4—0.

This was a very disappointing game for Guy's who, on form, should have won the game easily. Instead they paid the penalty for poor covering and bad finishing; let's hope the lesson has been learnt!

Guy's: *M. Carter; I. Nash, P. Evans; I.* McClure, S. Watt-Smith, R. Lovell; D. Jacobs, I. Harrison, R. Davey, E. Elias, D. Lindridge (Capt.).

WATER POLO

GUY'S v. LONDON HOSPITAL

Tuesday, 14th November 1967

Result: won 6—5

Almost to the end of this game it appeared that the tables were going to be turned for the first time this season and the London were going to beat Guy's .But a fighting last quarter, culminating in a penalty earned and crashed home by Challacombe just saw Guy's through the game they needed to win to be virtually certain of second place in the United Hospitals League.

Unusually, Guy's did not go into an early lead, and had to pull back a two goal deficit to be level at the end of the first quarter with goals from Challacombe and Northcott. Challacombe injured his jaw, and hung back in the next quarter in which there was no score. Challacombe's strength in front of goal was certainly missed—his injury must have cost a couple of goals. Yet when back in action in the third quarter he was well marked, and the London had a good period when they opened a worryingly large gap between the scores. When Howard, who had done some good saves at the other end, fell for a long lob, it was the London's fifth goal. Fortunately Challacombe scored another of his typically brutal goals to put Guy's into the final quarter with an outside chance of victory, trailing by 3—5.

And Guy's did fling everything into it. They gave the London no chance to linger in possession and forced them into poor passes, giving the possession that Guy's needed for Challacombe to score again and then for Northcott to score. One fine attack for the winning goal only just failed as Froom's shot hit the bar. Then Challacombe forced one of their players into their third major foul, for which a penalty is awarded, and he made no mistake with the shot which won the match.

Guy's: Howard, Foulds, Froom, Northcott, Challacombe (Capt.).

HOSPITAL INFORMATION

APPOINTMENTS VACANT

GREENWICH DISTRICT HOSPITAL

St. Alfege's Wing, Vanbrugh Hill, S.E.10. (500 beds) Recognised for D.C.H.

Senior House Officer (General Medicine and Paediatrics) from 1st January. Six months' appointment (renewable). Write with testimonials/references to Group Secretary, G. & D. H.M.C., at hospital.

GUY'S HOSPITAL

Applications are invited for the post of **Senior Registrar in Thoracic Surgery** with duties to commence 17th February, 1968, and appointment until 30th September 1968 in the first instance. Forms of application are obtainable from the Superintendent, Guy's Hospital and should be returned not later than **4th December, 1967.**

GUY'S HOSPITAL AND SOUTH-EAST METROPOLITAN REGIONAL HOSPITAL BOARD

Applications are invited to fill an established vacancy for the appointment of **Senior Registrar** in Psychological Medicine to the Board of Governors of Guy's Hospital and the South-East Metropolitan Regional Hospital Board. The appointment will be for four years from 1st December 1967 (or as soon as possible thereafter) with duties initially at St. Olave's Hospital and for the remainder of the appointment with the Bexley Group and at Guy's Hospital. The post, which will be reviewed annually, is subject to the Terms and Conditions of Service of Hospital Medical and Dental Staff (England and Wales). Forms of application are obtainable from and should be lodged with the Superintendent, Guy's Hospital, S.E.1. not later than **30th November, 1967.**

PERSONAL

BOURNEMOUTH, HANTS.—Associate required for fully equipped second dental surgery. Salary on high percentage basis. Full Clinical Freedom and chairside assistance. Box No. 1/11.

WANTED—Five roomed furnished flat or house in Greenwich required for family from middle December for one year. Tel:HOP 0254 evenings

MAIDENHEAD—Dental Associate, with definite view, to join two partners in well-established practice. Ample scope. Apply: M. H. O'Connell, 7 Castle Hill, Maidenhead. Tel: 20764.

CHANGES OF ADDRESS

Mr and Mrs. D. M. Balean, Cuckmere House, 1, Cuckmere Walk, Hampden Park, Eastbourne, Sussex.

Mrs. P. Emery, Standard Bank Ltd., P.O. Box 3003, Nairobi Kenya.

Mr. and Mrs. G. M. Evans, Silwood, 24, Wilderness Road, Chislehurst, Kent Tel: 01-467 0630.

John Maynard, 55 Wimpole Street, London, W.1. Telephone 01-935 8607. 31, Beech Avenue, Sanderstead, Surrey. Telephone 01-657 4143.

Mr. E. A. Moore, 83 Willingdon Road, Eastbourne, Telephone 28281.

Dr. and Mrs. A. J. Richards, M.B., B.S., 12 Dunoon Road, Honor Oak Park, London, S.E.23. Tel: 01-699 2194

Mr. O. H. Shaheen, 97, Harley Street, London, W.1. (Tel: Welbeck 7828)

BIRTHS

EMERY—To John and Pam on 4th September, 1967, at St. Munchins Maternity Hospital, Limerick, Ireland. A son John Gerard Brian.

ROSTEN—On 16th October, 1967, at Chiswick Maternity Hospital, to Greta (née Smith) and Deryke Rosten, a daughter, Lucy Jane, a sister for Martin and Emma.

WILDERSPIN—On Friday, 10th November, to Anne (née Bowes), M.S.R., and Michael P. Wilderspin, M.B., B.S., a daughter, Alison Rachel, sister for Heather and Stephen.

WILLIAMS—On 7th November, at Brighton, to Sylvia (née Norris) and Philip ("Paddy") Williams, a son, Andrew Dalton.

We would like to remind our readers that all copy for inclusion in the Gazette must be received eight days before publication date.

Personal notices and Birth, Marriage, and Change of Address notices must be pre-paid.

Personal notices one shilling per word (minimum £1. 1s. 0d.)
Birth, Marriage, Death, and Change of Address notices are without charge to subscribers.

Non-subscribers will pay £1. 1s. 0d. (pre-paid) for all notices other than Death.

GUY'S HOSPITAL GAZETTE

EDITORS C. B. BROWN and P. J. DAVENPORT
SPORTS CORRESPONDENT J. G. PAYNE
NURSING CORRESPONDENT E. A. MALPAS

FORTNIGHTLY TWO SHILLINGS VOLUME 81 NUMBER 2071

The opinions expressed in these columns are solely those of their authors and are not to be taken as the views of the Hospital as a whole.

PASSIM

Junior Hospital Doctors' Association/B.M.A. Talks Imminent

The Junior Hospital Doctors' Association have now submitted to the B.M.A. a memorandum on representation of hospital junior doctors within the B.M.A. and this will be the basis for forthcoming talks between the two associations.

The Junior Hospital Doctors' Association proposes a new parallel structure similar to that which already exists for consultants and which has existed for many years in other European countries.

Junior staff should be represented on all hospital committees and this would be the basis from which the regional and central organisations would grow. As the memorandum points out, all junior staff work full-time in hospitals, but consultants are only part-time.

In addition, the memorandum draws attention to the fact that it is essential for the extremely cumbersome machinery for creating new additional consultant appointments to be streamlined.

Dr. Joe Briggs, Chairman of the Junior Hospital Doctors' Association, said: "Our proposals are reasonable and practical and we think they will be acceptable to all hospital junior doctors. Although there are almost twice as many hospital junior doctors as consultants, we are not only asking for an egalitarian system of representation but a constitutionally protected one. These proposals are now the concern of the B.M.A. Council, following the Annual Representative meeting in Bristol on 8th July this year.

"We hope these talks will proceed smoothly and quickly. If the proposals are accepted it would then be up to all hospital junior doctors to make them work by supporting the new constitution."

The Royal College of General Practitioners

The fifteenth Annual Report of the College of General Practitioners makes exciting reading. The highlight of the Report is the publication of the letter from the Home Office conveying the command of the Queen that, in future the College should be called the "Royal College of General Practitioners", but the remainder of the Report is no less a cause for congratulation.

The College was founded in 1952 and has premises in Prince's Gate, S.W.7. It now has a membership of 7,466 general practitioners, including some from Eire, New Zealand, South Africa, Kenya and Uganda. Its activities are largely confined to G.P. education and research, but they also run a successful residential Club, a museum and a library at their London premises.

The contents of the report show that a wide spectrum of G.P. activities is investigated by the College; it extends from the subject of undergraduate and graduate vocational training, through advising on the planning of the medical services in the new town at Woolwich, to providing what is described as "an internationally known library of educational recordings".

The research activities of the College are too numerous to mention them all here, but the work of the Epidemic Observation Unit deserves special mention. G.Ps. are especially well equipped to supply a steady flow of clinical information on requested topics to the researchers at the College; Oral contraceptives, Reactions to Measles Vaccination, and Leukaemia and Aplastic Anaemia in Children are only three subjects from a list of 14 under review.

The Education Committee is reviewing the education of both the G.P. and his patients. They recently (August 1967) published their report on "The Implementation of Vocational Training". A conference is planned for next year at which representatives of the College, Deans of Medical Schools, Post-gradute Medical Schools and Regional Post-graduate Centres will discuss this report. This conference has been called "probably the most important movement to have affected General Practice since the inception of the National Health Service".

It is to be hoped that the emphasis placed on Vocational Training by this, now, Royal College will not be ignored by those responsible for student education. It is true that at Guy's we have a G.P. research unit, and that there is an arrangement for students to spend time working with a G.P. Perhaps, after the proposed conference on the College's Report, there will be even more undergraduate training for that part of Medicine that will be, for most of us, the eventual and, judging from the Report, an interesting medical career.

At the recent Gazette Committee Meeting, Dr. Stephen Robins profered his resignation as Editor of the *Gazette*, the post which he held for a year subsequent to being Assistant Editor for nine months. For truly his absence will be missed from St. Thomas's Street. Mr. Peter Davenport, Secretary of the Theatre Club and Treasurer of the Students' Club, was elected Assistant Editor.

We would like all readers, especially those at Guy's, to know that those interested in submitting articles to the *Gazette* may do so into our newly-acquired pigeon-hole in the East Wing, or through the Front Lodge as before.

All subscribers to the *Gazette* are offered the opportunity to express their Christmas Greetings in the next special Christmas issue of the *Gazette*. Greetings to reach the Gazette Office not later than December 14th. The usual rate for Personal insertions will be charged.

GUY'S DIARY

We offer our congratulations to Mr. W. I. N. Forrest (Surgeon Captain, R.N.) on his promotion to Surgeon Rear-Admiral, as Director of the Dental Service of the Navy.

DECEMBER

11th	M.	1.00	Clinical Lecture, Mr. KINDER. "Tumours of the Upper Urinary Tract."
		12.15	Dental Lecture. Dr. CAHN. "Global Oral Pathology." [Dental Theatre.]
12th	Tu.	1.00	Clinical Lecture. Dr. GRIMBLE. "Mycoplasma."
14th	Th.		Clinical Lecture. Dr. CARNEGIE. "Local Analgesia in General Practice."
15th	F.	1.00	Clinical Lecture. Mr. BRAIN. "Present Problems Posed by Pulmonary Tuberculosis."
18th	M.	1.00	Clinical Lecture. Lord BROCK. "Cancer of the Lung."
19th	Tu.	1.00	Clinical Lecture. Mr. BEARD. "Femoral Hernia."
21st	Th.	5.30	Neurosurgical Round. Mr. P. H. SHURR. Clinical Theatre.

Christmas Services in Guy's Hospital Chapel

Tuesday, 19th December: *8.30 p.m., The Festival of the Nine Lessons and Carols.

Christmas Eve: 6.30 and 8.50 a.m., Holy Communion. *10.45 a.m., Morning Service. *11.30 p.m., The Blessing of the Crib and the Midnight Eucharist.

Christmas Day: 6.30 and 8.50 a.m., Holy Communion. *10.30 a.m., Christmas Morning Service.

*These Services are relayed to all Wards.

The Collection at the Festival of Lessons and Carols will be given to the South Bank Housing Society; on Christmas Eve to the Telephone Samaritan Service; and on Christmas Day to the Children's Society.

HODGKIN'S DISEASE

Brief notes made during a visit to M.G.H. Boston, dealing with one or two aspects of Hodgkin's Disease.

By Andrei Calin

For the purpose of this discussion, Hodgkin's Disease will be considered under five separate headings :—

1.—Prognosis.

2.—Treatment.

3.—Aetiological factors.

4.—Immunological factors.

5.—Alcohol intolerance.

Prognosis and Treatment

Prognosis and treatment are clearly defined on both sides of the Atlantic, apart from minor preferences in nomenclature and drug therapy. I have therefore confined my comments to the last three headings. My experience comes from conversing with Prof. Alan C. Aisenberg (Massachusetts General Hospital, Boston), his junior associates and his numerous papers on the subject.

Aetiology

(A) Hodgkin's disease is more likely, at least initially, to represent an infectious rather than a neoplastic process :—

1. The clinical picture is characterized by chills, sweats, fever, leukocytosis, anaemia, weight-loss and shows a spontaneous remitting course.

2. The histological picture is that of an atypical granulomatous process and one is hard put to identify the neoplastic cell. (The Reed-Sternberg cells are not found in sufficient numbers to satisfy this requirement. However, according to Spriggs A. I., and Boddington M. M., in a paper in the *Lancet* 2; 153. 1962, the chromosomal structure of this cell *is* consistent with a neoplastic origin.)

3. If infectious, the precipitating factor is more likely viral in nature (the possible bacteriological causes having been ruled out):—

   We know of the various viral tumours in animals (Rous chicken sarcoma, etc.), the evidence here and for other animal cancers of the lymphoid cell series is particularly good. In many cases, cell-free agents have been isolated from transplanted animal tumours, but there is no human parallel. (The geographical distribution of the malignant lymphoma of African children suggesting no more than the probability of the intervention of an insect vector.)

(B) By comparing the age incidence, the sex ratio and the survival figures, the only other point of interest is the fact that there is a 1 : 1 (male to female) ratio in the age-group under 40, but a ratio of 2 : 1 over 40, there being a more malignant course in the latter group (where some consider the disease to be a separate entity). Also, the incidence of Hodgkin's disease is three times greater in close relations (this also applies to many other carcinomas).

(C) Both tissue culture and electron microscopy studies remain inconclusive, and although cytoplasmic inclusions have been found in about 50 per cent of affected lymph nodes their specificity cannot be proven; direct innoculation of extracts of lymph nodes into laboratory animals fails to produce any compelling evidence. In the future, it is hoped to begin innoculation of such extracts into sub-human primates rather than attempt to draw evidence from non-primate work.

Immunology

The following immunological aspects have already been well defined :—

1. The predisposition of the patient to viral and mycotic infections (especially TB, cryptococcosis and Herpes Zoster).

2. The high incidence of Tuberculin negativity as part of a general unreactivity (=Anergy) to all allergens that ellicit the delayed type of skin reaction. (Immunological reactivity is divided into the immediate type, mediated by antibody and delayed type, mediated by cells and measured by skin sensitivity).

3. This anergy appears early in Hodgkin's disease while the condition of the patient is still good and often asymptomatic. The same anergy is present in the leukaemic and terminal carcinoma patient but only at a later stage. (Diphtheria toxoid and dinitrochlorobenzine, etc. are used as antigens in testing for anergy.)

4. One hundred per cent of Hodgkin's disease cases, with an active focus of disease, show this anergy, the normal skin reaction returning if the disease becomes quiescent for more than two years.

5. During the early stages, the patients also show a delayed homograft rejection.

6. Antibody formation has been shown to remain until terminal stages in the disease (i.e. immediate type of immunological reactivity).

7. Hodgkin's disease forms a striking contrast (in the early stages) with chronic lymphocytic leukaemia and other forms of hypogammaglobulinaemia and agammaglobulinaemia in which the characteristic findings are depressed gammaglobulin, poor antibody formation and bacterial infection.

8. Patients with Hodgkin's disease, unlike controls, do not accept the transfer of delayed hypersensitivity with whole leukocytes from hypersensitive donors. Work is presently being carried out to determine whether patients with Hodgkin's disease still possess a transfer factor.

9. Children lose tuberculin sensitivity during the course of measles.

As the anergy is seen in patients even with only localized disease, the obliteration of the entire lymphoid system is hardly an explanation.

More recently, two diseases produced experimentally in animals have helped to evaluate these interesting factors further:—

1. Genetically foreign material (e.g. spleen lymphoid cells) are injected into a newborn animal (which is unable to reject the graft): NEONATAL RUNT DISEASE is produced. This graft-versus-host reaction consists of lymphadenopathy, splenomegaly, leukocytosis, skin lesions, diarrhoea and finally death.

   Apart from the skin lesions, intestinal rush and lack of fever the disease is remarkably similar to Hodgkin's disease.

2. The WASTING DISEASE seen in thymectomized animals shows similar features; the disease being characterized by lymphocytopaenia, wasting and death (lymphocytopaenia, of course, not being a characteristic of early Hodgkin's disease). These neonatally thymectimized animals can be restored by thymuses contained within a diffusion chamber suggesting a humoral factor subserving the immunological function of the thymus.

Although the contention that all Hodgkin's disease originates in the thymus is no longer seriously considered, reappraisal of the thymus is thought to be an important further step and work is now being done.

Anergy of early Hodgkins' disease is now considered to be a peripheral defect—a manifestation of abnormal lymphocyte function : in advanced Hodgkin's disease profound lymphocytopaenia probably contributes to the more severe immunological deficiencies (as it does in uraemia or advanced carcinoma). This conclusion was reached after a quantitative estimation of the reactivity of normal and Hodgkin's disease lymphocytes, using thymidine $-2-^{14}C$ (the lymphocyte reactivity in vitro should also provide insight into the pathogenesis of other diseases involving immune/autoimmune mechanisms and into the human organ transplantation problems). Dr. Aisenberg produced a simple technique for determining lymphocyte reactivity based on the incorporation of ^{14}C labelled thymidine into the D.N.A. of reacting cultured lymphocytes. The response pattern of lymphocytes from anergic Hodgkin's disease patients shows a depressed reactivity to various stimuli (e.g. Phytohaemagglutin) as compared to those of a control.

These results are in keeping with the other observation that the local skin reaction following transfer of Hodgkin's lymphocytes is depressed. Hodgkin lymphocytes and lymphocytes from a normal control were injected subcutaneously into a normal recipient. At 48 hours there was no difference but at 7-14 days the reaction to the Hodgkin's disease lymphocyte faded but that to the normal lymphocyte persisted. This difference was more conclusive when a Hodgkin's disease recipient was used—presumably because of the anergic state of the Hodgkin's disease patient allowing more persistent reaction to be observed. (A similar transfer experiment with uraemic subjects also suggests such a defect.)

Alcohol Intolerance

And finally, to deal with the question of alcohol intolerance in neoplastic disease; T. B. Brewin described in the *B.M.J.* of 20th August, 1966, a study of 192 patients with diagnosed Hodgkin's disease in whom 31 per cent showed some degree of intolerance to alcohol ranging from slight ache in the affected nodes to a severe systemic upset reminiscent of the effect of disulfiram ("antabuse") in alcoholism. This intolerance may:—

1. Appear as a very early symptom of local neoplastic change;
2. Disappear after small doses of radiotherapy; and
3. Be suppressed by small doses of cytotoxic drugs.

Apart from polite interest shown in my questioning on this subject, I could find no physician of Hodgkin's disease in Boston or the cancer hospital of Missouri who has been aware of this possible correlation and realised after brief discussion that I would learn nothing on this subject from further enquiry.

Summary

1. Dr. Aisenberg and his associates have recently defined to a greater extent the peculiar cutaneous anergy of Hodgkin's patients. This anergy is a defect in delayed immunological reactivity, expressed at a cellular level.

2. The lymphocytes are quantitatively similar but qualitatively inferior to those of a control. The abnormal lymphocyte is presumably the cause for the immunological defect.

3. This defect is found in other acute viral conditions (e.g. measles).

4. Review of the incidence and natural history suggest a different process in patients older than 40 years, possibly with different aetiology.

5. In the near future, more work will be done on the rôle of the thymus and on innoculation of diseased lymphoid tissue into subhuman primates, continuing the search for a possible virus.

6. Direct evidence of a viral causation is still lacking but evolution of the field of tumour viruses increase suspicion that such an agent is involved.

7. Both the histology and clinical picture do not permit one to accept readily that the disease is a conventional neoplasm. Perhaps in individual cases, a true neoplasm follows a pronounced period of viral induction.

8. In my very localized and brief experience, the Americans do not show any interest in the effects of alcohol inducing pain in malignant tissue.

References

1. Quantitative Estimation of the Reactivity of Normal Hodgkin's Disease Lymphocytes with Thymidine-2-^{14}C. Dr. Alan C. Aisenberg. *Nature*. 205, 1233, March 20th, 1965.

2. Medical Progress. Dr. Alan C. Aisenberg. *New England Journal of Medicine*. March, 1964.

3. Studies of Lymphocyte Transfer Reactions In Hodgkin's Disease. Dr. Alan C. Aisenberg. *Journal of Clinical Investigation*, vol. 44, 4, April, 1965.

4. Antibody Formation In Hodgkin's Disease. Dr. Alan C. Aisenberg and S. Leskowitz. *New England Journal of Medicine*, 268, 1269, 1963.

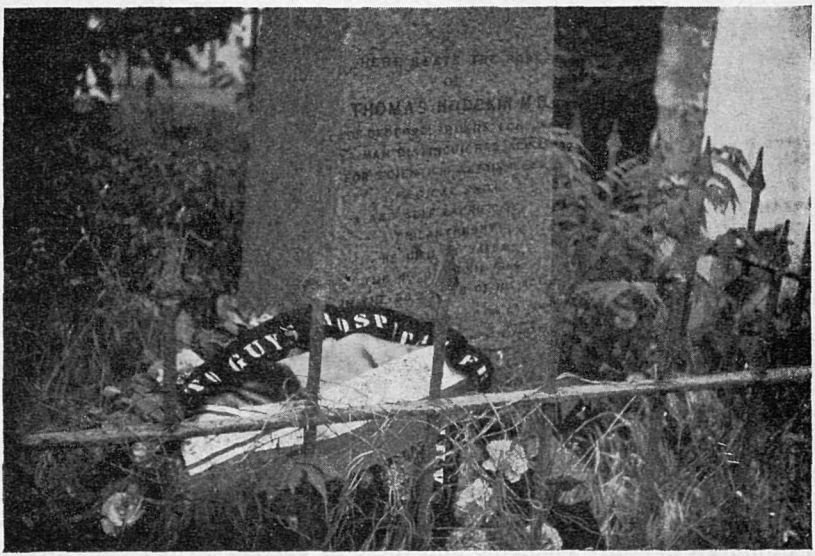
5. Alcohol Intolerance In Neoplastic Disease. T.B. Brewin. *B.M.J.*, 20, 8, 1966. 1966.

6. Autoimmunity In Man and Homologous Disease In Mice In Relation to Malignant Lymphomas. H. S. Kaplan and D. W. Smithers. *Lancet*, 2, 1-4, 1959.

HODGKIN'S GRAVE

by

Henry Windsley



On Monday, 22nd May, I resided in Hezlia-Pituah, Israel, and planned this day to pay my tribute as an ex-Guy's student to Thomas Hodgkin, physician and philanthropist, who found a resting place in the Holy Land when on a pilgrimage with his friend, Sir Moses Montefiore. War clouds were already appearing on the Egyptian horizon when I made my way to the cemetery next to a school, under the auspices of the Church of Scotland, in Jaffa (Tel-Aviv).

Thomas Hodgkin received his medical training at Edinburgh, in Scotland, before taking up his post as Curator to the Gordon Museum at Guy's. As it happened, by coincidence, the day of my visit was crowned with a victory of the Scottish football team over Israel! The sun was already setting when I gained access to the graveyard. It was not long before I was faced with a magnificent obelisk bearing the inscription of a great Guy's man. Its position gave a favourable prognosis as it was near the fence of the cemetery, on the other side of which an occupied house, with washing hanging on a line, showed that this message of death can be masked by life.

From personal observation, the ground surrounding this emblem of wisdom appeared to be in need of a gardener. Somehow there appeared a resurrection of the story in Genesis of Man being banished from the Garden of Eden and told to till the soil as punishment for following the serpent's path. Maybe this obelisk of Thomas Hodgkin gives out a call to doctors, and especially Guy's men, to solve the riddle he described last century and open a new book of the Holy Land.

WILLS LIBRARY ANTIQUITIES

11. SIR JAMES EDWARD SMITH

by William Hill

Among the more distinguished lecturers at Guy's was Sir James Edward Smith, who taught botany during the last years of the eighteenth century.

James Edward Smith was born in Norwich in 1759. It is said that his mother fostered his love of botany as a child but that his serious study did not start until he was eighteen and, by one of those odd coincidences, on the day of Linnaeus's death. In 1781 he went to Edinburgh to study medicine and there he carried off the gold medal for botany and founded a natural history society. In 1783 he was in London as a pupil of John Hunter and where he came into contact with Sir Joseph Banks, President of the Royal Society.

In 1783 the Linnaean collection was offered to Banks for a thousand guineas. Banks refused the offer but persuaded Smith to purchase it. The collection arrived in London in October 1784, and was displayed at Smith's house in Chelsea. There is a story that, on hearing of the transaction, Gustav III of Sweden sent a warship to intercept the vessel carrying the collection but there seems to be no foundation for the account. It is, however, commemorated in the portrait of Smith which appears in Thornton's *Temple of Flora.*

Having arranged the collection for the time being, Smith left London and toured Europe for a year or so. His first stop was at Leyden, where he submitted a thesis for the M.D. From Holland he travelled through France, Switzerland and Italy finally reaching Naples, where he stayed with the Hamiltons, Nelson's Emma. While on the tour he spent as much time as possible in libraries and museums. The account is written in three volumes published on his return to England.

He settled in London and contemplated practice as a physician. For some years he had considered the formation of a society for the study of botany and in April 1788 the first meeting of the society took place in his house. This was the foundation of the Linnaean Society, which started with thirty-six members with Banks as an honorary member. He abandoned his intention of practising medicine and devoted himself to botany, firstly giving lectures at his house. Among his pupils were the Duchess of Portland and Viscountess Cremorne. He was appointed lecturer to Guy's Hospital and for several years gave a course of lectures on botany.

The Wills Library possesses two manuscript copies of his lectures, one written in 1795 by Isaac Tupper, and one two years later by Martin Tupper. Isaac has illustrated his with pen and wash and was later to become a well-known botanical artist. Another of the artists associated with Guy's later in the nineteenth century was John Tupper. Both manuscripts record eighteen lectures and are carefully written and can be easily read.

In 1897 he married and returned to Norwich, where he remained for the rest of his life, spending several months a year in London giving his lectures. During the period 1790 to 1814 he issued his most famous work, *English Botany,* in 36 volumes. His name does not appear on the title pages of the first three volumes and consequently the work is more commonly known as Sowerby's Botany, after the artist who prepared the 2,590 plates of all the well-known British plants.

At one time he was asked, through the influence of Viscountess Cremore, who had been one of his early pupils, to arrange an herbarium for the Queen and to give lessons on botany to her daughters. Unfortunately, praise of Rousseau and attacks on Marie Antoinette in his travel books caused the Court to have doubts about his loyalty. These remarks were removed from the second edition.

During his life he received many honours and in 1814 he was knighted. In 1818 he was invited to lecture at Cambridge but the University authorities objected on the grounds that he was a unitarian. This caused him to write two acid pamphlets on the subject. When he died his library and collections were offered to the Linnaean Society for £4,000 and were purchased by private subscription for a smaller sum and presented to the Society. During his life he wrote many books and the Wills Library possesses a number of them. Apart from the Sowerby's Botany mentioned, it possesses his editions of Linnaeas's *Tour in Lapland* and *Flora Lapponica.* Other works are his *Grammar of Botany,* with beautiful illustrations and his *Flora Britannica* in three volumes. Several of these will be on display for the next fortnight.

QUIZETTE : Radiology

1. On a chest X-ray, a "coin" shadow containing calcium may be due to:
(a) Hydatid disease; (b) Secondary deposit; (c) Tuberculoma; (d) Carcinoma of the bronchus; (e) Hamartoma.

2. Pleural calcification may be due to:
(a) T.B. pleurisy; (b) Pulmonary infarct; (c) Asbestosis; (d) Haemothorax; (e) Scleroderma.

3. Rib-notching may be seen:
(a) In total anomalous venous drainage; (b) After Blalock operation; (c) In transposition of the great vessels; (d) In Neurofibromatosis; (e) In aortic coarctation.

4. Pulmonary infiltration with eosinophilia may be seen in infestation by:
(a) Clonorchis sinensis; (b) Wuchereria bancrofti; (c) Ascaris lumbricoides; (d) Actinomyces bovis; (e) Aspergillus fumigatus.

5. X-ray of the hands may show a characteristic abnormality in:
(a) Pretibial myxoedema; (b) Chronic renal failure; (c) Porphyria; (d) Scleroderma; (e) Polyarteritis nodosa.

6. Abnormalities on bone X-rays may be seen in:
(a) Acanthosis nigricans; (b) Psoriasis; (c) Lichen planus; (d) Atopic eczema; (e) Urticaria pigmentosa.

7. Periosteal reaction on a tibia may be due to:
(a) Varicose ulceration; (b) Carcinoma of the bronchus; (c) Fluorosis; (d) Paget's disease; (e) Hyperparathyroidism.

8. Sclerotic bone deposits occur in:
(a) Carcinoma of the breast; (b) Carcinoma of the thyroid; (c) Carcinoma of the prostate; (d) Hodgkin's disease; (e) Carcinoma of the kidney.

9. The affected kidney in renal artery stenosis may show:
(a) Notching of the ureter; (b) Clubbing of calyces; (c) Calcification of renal substance; (d) Delayed excretion of contrast; (e) Increased concentration of contrast.

10. Above what level of blood urea is an I.V.P. of little value:
(a) 50 mg. %; (b) 75 mg. %; (c) 100 mg. %; (d) 200 mg. %; (e) 400 mg. %.

11. In steatorrhoea the barium follow-through may show:
(a) Flocculation of barium; (b) Narrowing of the jejunum; (c) Widening of the jejunum; (d) Coarse mucosal folds; (e) Fluid levels.

12. Intracranial calcification may be expected in:
(a) T.B. meningitis; (b) Toxoplasmosis; (c) Craniostenosis; (d) Arnold-Chiari malformation; (e) Tuberose sclerosis (Epiloia).

QUIZETTE ANSWERS

1. **C, E.**
Tomography greatly increases the chances of showing calcification in any lesion. Calcification does not completely rule out a carcinoma; the incidence is probably about 1%,(Bateson, E.M., 1965, Clin. Radiol., 16, 51.)

2. **A, C, D.**
Pleural calcification occurs after exposure to asbestos even in the absence of lung changes or symptoms, (Hourihane, D.O.'B., et al, 1966, Brit. Med. J., i. 1069).

3. **B, D, E.**
The collateral circulation to the arm beyond the divided subclavian after Blalock operation may include the upper intercostals, Campbell, M., 1958, Brit. Ht. J., 20, 253).

4. **B, C, E.**
There is now little doubt that filarial infestation is one of the main causes of tropical eosinophilia, (Webb, J. K. G. et al, 1960, Lancet, i, 836). Allergic reactions to aspergilli occur in asthmatics and are often accompanied by transient lung shadows (Hinson, K.F.W. et al, 1952, Thorax, 7, 317).

5. **A, B, D.**
Thyroid acropachy may accompany pretibial myxoedema (Gimlette, T.M.D., 1960, Lancet, i, 22). Renal failure can lead to secondary hyperparathyroidism. Soft tissue calcinosis and bone resorption may be seen in scleroderma.

6. **B, E.**
Psoriatic arthropathy. Mastocytosis is sometimes associated with areas of bone sclerosis.

7. **A, B.**
As well as causing periosteal reaction chronic varicose ulceration can produce soft tissue calcification of the lower legs. (Sarkany, I. and Kreel, L. 1966, Brit. Med. J., ii, 27). Carcinoma of the lung is the commonest cause of hypertrophic pulmonary osteoarthropathy.

8. **A, C, D.**
Lytic deposits can also occur with all these conditions, particularly carcinoma of the breast.

9. **A, D, E.**
Notching of the ureter is a rare sign, produced by peri-ureteric collaterals. Increased concentration on the affected side corresponds to the altered pattern of excretion of water and sodium found in some patients with renal artery stenosis (Brown J. J. et al, 1960, Brit. Med. J., ii, 327).

10. **E.**
The examination of patients with elevated blood urea, (Schwartz et al, 1963, New Eng. J. Med., 269, 277) has proved of remarkable value provided high doses of contrast (containing about 20-30 grammes of iodine) are used and the kidneys are tomographed. It is usually possible to determine (a) renal size (b) presence or absence of obstruction in patients with blood urea up to these levels and possibly even higher. Excess contrast can escape in the bile, (Chamberlain, M. J. and Sherwood, T., 1966, Brit. J. Radiol., 39, 765).

11. **A, C, D, E.**
(Laws, J. W. et al, 1963, Brit. Med. J., i, 1311).

12. **A, B, E.**
In T.B. meningitis calcification only develops with healing, (Lorber, J., 1952, Arch. Dis. Childhood, 27, 542) and is not seen in the acute stage.

Compiled by H. M. Saxton

George Sperryn-Jones

George Sperryn-Jones, qualified L.D.S., R.C.S.(Eng.) at Guy's in 1938; his death on October 26th was a great shock to his many friends and patients.

He was married to Margaret Golds (Guy's S.R.N.) in 1939 and served in the Royal Army Dental Corps throughout the War. The majority of his Short Service Commission was with field rank in the 1st and 4th Army in India. He then accepted a two-year government post in Queensland, Australia, before returning to England and establishing a large and busy group practice in Woking.

A man with great personal charm and sense of humour, who never ceased to give his best to others, his energy and integrity were recognised in many fields. He founded the Woking Dental Society, took an active part in British Dental Associations affairs, and was a member of the British Society for the Study of Orthodontics and the Royal Society of Health. He was elected as a Liberal member of the Woking Council in 1961, and appointed as Justice of the Peace in 1966. Always a keen and sincere church worker, he served on his Parochial Church Council and as a Churchwarden—he will be greatly missed by many youth organisations who had the benefit of his most active and vigorous help.

Guy's men can be proud of "George" who so typically bequeathed his body to the hospital, and all who knew him will wish to express their sympathy to his wife, Peggy, his daughter and two sons at this sad time.

R. D. Ogston

NURSING SECTION

Aid or Hindrance

Mechanical aids are the inevitable outcome of modern technology, but how they are used in hospitals or how they are received in hospitals depends very much on the atmosphere in which they are introduced, and also the optimism of the people concerned in their operation.

Housewifery is now made pleasant by the so-called labour-saving devices and there are very few drudgery tasks which in the past made life miserable for the housewife or servant.

Work study experts and the Medical Research Council have now decided that labour-saving devices are necessary for nurses in hospitals. It has never been the nurse who has decided that her labour has needed saving!

Whether machinery is acceptable to the patient or nurse is a debatable question. Certainly a machine capable of performing routine but necessary observations saves the nurse's time and also saves the patient from being disturbed when he wishes to rest. However, there is always the point of whether there is machine infallibility just as there is human error.

Does one spend more time observing the machine? Does the patient come in for a cursory glance only? Possibly when one is ill one prefers to be left alone, and if merely being connected to a machine suffices to give the medical staff the knowledge of the patient's condition, then maybe certain patients would prefer this to the continual hovering of the nurse.

However, humanity plays an important part in mental well-being and the presence of the nurse may do much to relieve the patient's anxieties which have a great bearing on his physical condition.

Statistics show that the number of nurses during the next few years will inevitably be reduced due to the reduction of young women to young men ratio. This may be overcome by removing the number of unnecessary tasks which are carried out by nurses—such as recording observations on the ill patient, thus allowing the nurses to spend more time on his general comfort.

If this state comes about it can be seen that we are going to educate a number of young women who are going to be of little help to the patient or doctor. They will never be able to gain the experience of knowing or being able to foretell changes in a patient's condition which only physical contact with the patient can tell you.

It is also going to be necessary to change the training of young nurses so that they can read electrocardiographs and the like—this takes the nurse away from the bedside and makes her an embryo doctor. One might as well train technicians for this type of work.

As has been said—machinery is inevitable, but whether the computer-type is going to prove satisfactory only time will tell.

STAFF CHANGES AND APPOINTMENTS

Appointments

C/N G. Loveless, (Guy's 1961-1965) promoted to Sister of Esther Ward.

Departures

Sister A. L. Amsden, from Assistant Matron (Planning).

Sister B. G. R. Barker, from Assistant Matron, Matron's Office.

Sister B. Edwards, from Esther Ward.

Sister A. Frost, from Administrative Sister, Matron's Office.

CORRESPONDENCE

Compassion or Confusion?

SIR,—I write to answer some of the statements made in an article headed, "Our Compassion", in the Nursing Section of the *Gazette*, dated 11th November, 1967.

I can see no useful purpose whatever in the writing of such a product of muddled thinking, which can only serve to undermine the high ideals of those who minister to the sick, and to disillusion members of the general public who read this outburst.

It was full of the most sweeping generalisations, for which individual can speak for either. "Twentieth-century man . . ." or ". . . those who care for the sick,"—or for the general opinion of people to-day ? It would have been better if the writer had used the first person singular throughout !

In my ministry, six years of which has been spent as a full-time Chaplain, I must have spoken to many thousands of patients in Hospital. With very few exceptions, they place doctors and nurses, and all members of Staff on a very high pedestal, and are full of praise and admiration for them. It is a pedestal, in my own judgement, that is richly deserved. In the life of a Hospital Ward, patients and relatives are aware that they are in a caring and compassionate community, where people are doing a vital and important job, which demands high standards and lofty principles, and a true sense of vocation. They tell me how different they find this atmosphere from the selfish, grabbing, materialistic world in which they usually struggle to exist. Is the writer trying to destroy one of the last places where people do care for each other, and where the whole life of the community is geared for the single purpose of restoring the sick, prolonging life, and the conquest of sickness and disease ?

When the Staff of Hospitals "are no longer inspired by the image of the Good Samaritan", the "second-best is all too readily accepted . . .", and they conform to the gloomy and despondent picture portrayed by the author, it will be time to close the gates of Guy's, and all other hospitals, permanently.

Yours, etc.,

REGINALD BEEVERS
Resident Chaplain

The Chaplain's Office,
Guy's Hospital,
London, S.E.1.

"Our Compassion"

SIR,—Having read Mr. Cobell's article, it is quite obvious that any sense of vocation he may have had for nursing in the past has now completely vanished.

He should look for another position but one not connected with nursing.

In view of the fact that Guy's Hospital hopes to attract male nurses, he must have damaged any chance they may have had of being successful, and further prejudiced those men and women, who may, from the start have been opposed to the introduction of male nursing staff in this great teaching hospital.

One may ask if these are Mr. Cobell's views, why then did he take up nursing? He must have known that any man who hoped to get married and raise a family would be living on a very small salary. Furthermore, if he had a desire to help suffering humanity, why not become a doctor? In these days of substantial grants from the tax payer, the expense of training should not have been an insuperable obstacle.

We live in an age of disillusionment, and it is nice to think that the public still puts medicine and nursing on a pedestal. The reason is not hard to find, of all the professions, both these are the least materially minded, although we are fully aware that every profession has the "odd black sheep" medicine and nursing have fewer than most.

As the girl of today can earn far more in commerce than in nursing, one must ask if it is not this desire to help their fellow men and women, that brings them into the profession?

Although aware of the low salary scale, 225 girls have this year entered the training school at Guy's Hospital, which seems a staggering number to a layman such as myself. If it is not a sense of vocation, what is it that attracts these young ladies to the profession?

I am surprised that so many of the nurses to whom I have spoken seem unaware of their own potential, for to a fully trained nurse, the world is her oyster. She can travel, write, and put her hand to anything.

She is fully accepted into society, and a girl has only to mention she was trained at Guy's, Bart's, Thomas', or one of our good provincial teaching hospitals and eyebrows are raised, the reason being that even the dimmest of laymen know that those hospitals have only girls of the highest standards.

With regard to doctors, I have experienced on a number of occasions how members of the medical profession put the welfare of their patients before their own interests and I have frequently been present when doctors have sacrificed a social engagement or an evening at the theatre to visit the bedside of a gravely ill patient.

If these men had been dockers, or members of any large union, they would probably have not turned out, or if they had, would have received overtime at an exorbitant rate.

Yours, etc.,

F. J. PITTS

7, De Montfort Road,
Streatham, London, S.W.16.

Uniform Changes

SIR,—The sixth paragraph of the comments included in your edition of November 25th requires some clarification as it omits the chief clause which governs the award of "Strings". Due to the revised plan for student nurses' training, the previous regulation relating to the record of practical work will of necessity be changed. Nevertheless, the most vital assessment for the award of "Strings" remains totally unaltered. Student nurses will be eligible for their "Strings" upon completion of a satisfactory record of the first two years of training: each individual's ward reports and overall contribution is assessed and—as now—will continue to be the decisive factor as to whether the award is given when due. Student nurses are fully aware that the wearing of "Strings" denotes primarily that the individual has proved herself to be a responsible and competent person.

The "Head Nurses" of today are expected to shoulder far greater responsibility than previously. They are a credit to themselves and to Guy's—each one has gained her "Strings" on merit and personal effort—and not just collected them at a certain date in the calendar, such as the writer of the Nursing Section implies !

Yours, etc.,

ANNE M. JOHNSON

Matron's House,
Guy's Hospital, London, S.E.1.

A Belt from Stripes

SIR,—I apologise for asking again for space in the *Gazette* but if no one else answers the query about "Stripes" may I do so? Stripes were instituted because there were no belts. Before the appointment of Staff nurses, no nurses wore belts. Sisters have never worn them. Apron bands were so made that belts were considered unnecessary. Stripes certainly looked to better advantage when nurses wore long sleeves and the stripe went all round the sleeve, just below the elbow.

There was a good deal more to them than the satisfaction of getting them. To mention two things, they were not given until the nurse had passed her examination in pharmacology and dispensing. She was then allowed to give medicines. Stripe Nurses took the night slip to the Matron's Office; her introduction to official reporting. More important than the symbol, is the ability to take the responsibility it entails. I hope present and future nurses will be as proud of their belts as we were of our stripes.

Yours, etc.,

FLORENCE TAYLOR

2/103, Blackheath Park,
S.E.3.

Auxiliaries Exeunt ?

SIR,—As the originator of the correspondence on Auxiliaries, I hope I may be allowed to express my regrets that so little of any real value seems to have been obtained from it.

I had hoped it would have been possible to have some serious comments on my two main points, which essentially were:

(1) In a profession such as Dentistry, where we have only limited means, should we not continually re-assess all our projects so that we obtain maximum effect with our money? How does the Auxiliary scheme stand in this light?

(2) Before introducing yet another grade into the profession, should we not have had a clear definition of what exactly the Dental Surgeon himself will be able to do under the State Services?

It seems, however, that the mere mention of the words "auxiliary" or "marriage" triggers what can only be described as an emotional response from some. The result has been a verbal fogscreen from which we have been subjected to a baffling barrage of totally irrelevant material. I regret I am unable to see any escape from this, and can only remain

Yours, etc.,

R. C. PATERSON

Dental Department,
Guy's Hospital, S.E.1.

[*Eds.—This correspondence is now closed*]

Ladies' Association Bazaar

SIR,—May I, through the *Gazette,* thank all those who so generously contributed to the success of our Bazaar, by their donations, gifts, and help.

The sum of £982 12s. 1d. was raised, and with a few belated donations yet to come, the final total of £1,000 may be reached.

This money will be used to provide extra comforts for the patients.

Your readers may like to know the names of the winners of the main prizes in the Draw.

First Prize—£25: Miss Diana Heyman, 25, Burnsall Street, Chelsea, S.W.3.
Second Prize—Kodak Instamatic Camera: Mrs. Lawson, 1, Portland House, High Trees, Upper Tulse Hill, S.W.3.
Third Prize—£10 *Harrods Voucher*: Betty Lockaby, c/o Mrs. Cohen, 2, Mansfield Street, W.1.
Fourth Prize—Case of Assorted Wines: Mrs. Kathleen Evans, 10, Boughton House, S.E.1.
Fifth Prize—Voucher for Theatre Tickets: Murray Milne Ltd., 28, Sackville Street, W.1.
Sixth Prize—Ladies' Outfit by Mary Quant: Mrs. Pearson, 50, Carr Green Drive, Rastrick, Brigehouse, Yorks.

In addition to the above there were 53 consolation prizes.

M. K. SALMON
Hon. Secretary

Guy's Hospital, S.E.1.

REVIEWS

INFECTIOUS DISEASES.

by A. M. Ramsay and R. T. D. Edmond. Published by Heinemann Medical Books Limited, London.

The advent of effective immunisation and vaccination, antibiotic therapy, and the rising standards of public hygiene have resulted in a remarkable decrease in the incidence of, and mortality from, the common infectious diseases in the United Kingdom. As a result of this, the speciality of Infectious Diseases has contracted, and indeed is no longer recognised by the Royal College of Physicians of London. This has produced a most unfortunate situation. The new generation of physicians no longer has, nor feels the need for, a thorough knowledge of microbiology. Antibiotics are used irrationally and haphazardly. Undiagnosable patients receive the label of "virus infection" as if this were an acceptable diagnosis, which is analogous to the labelling of all polyarthropathy as "Collagen disease" without attempting to investigate the condition further. In no other field can one find a situation in which the rarer a disease becomes, the less a physician is encouraged to obtain specialist experience in its diagnosis and management. There is no ready answer to this paradox, but while it exists, the need for books such as that written by Ramsay and Edmond becomes vital. In their preface, they state that the book "purports to furnish the basic facts regarding the common infections encountered in the British Isles and so affords a basis for training of undergraduate and post-graduate alike". It achieves its aims admirably. The text is clear, concise and readable. The illustrations are excellent although they suffer to some extent by being removed from the text of their subject matter. The content is up-to-date and the references to many of the chapters, such as that on rubella, are excellently chosen. My criticisms are few. The references at the end of some of the chapters such as that on infectious mononucelosis are rather meagre. A preliminary chapter on the classification of micro-organisms would have been valuable.

I feel the chapter on chemotherapy is rather inadequate and incomplete, for it includes no mention of the newer tetracyclines, which would appear to have clear cut advantages over the more traditional preparations. However, these are small points. This book deserves a place on the shelves of all undergraduate and post-graduate libraries. It will be invaluable to any general practitioner, and a good investment to any student who can afford it.

IAN MCGILL

A HANDBOOK FOR NURSES. COMMON MEDICAL AND SURGICAL CONDITIONS.

by N. C. West. E.U.P. *Price* 8*s*. 0*d*.

In her introduction to this book, the author states the aim to be towards the first-year student nurse, the pupil nurse, and the nursing auxiliary; this might appear to satisfy a gap in the literature, but many student nurses may well feel this to be a waste of money, whereas nursing auxiliaries or pupil nurses with a language problem may find the going difficult at first.

The book is arranged in encyclopaedic form and the author has attempted to limit herself to commoner conditions which would be met in the wards of a general hospital. The format, naturally, within the limitation of 86 pages, lends itself to omission and inadequacy, but access to a dictionary should make good these deficiencies.

The author also makes reference to nurses wishing to return to nursing after a number of years. Such nurses would probably prefer a more complete work of reference, but there may well be a place for a library edition of the book rather than the paper-back.

There are a few typographical errors and a number of cross references in the text. The use of lay terms seems unnecessary.

Mention is properly made of newer drugs and the section on Insulin is particularly valuable.

P. NUSWORTH

SPORT

RUGBY

The vast Campus of Loughborough Colleges impressed the visitors of the progress of modern education through its architecture (in particular the 23-storey Hostel) and by the abundance of equipment that surrounded the Guy's side while they changed in the North Gymnasium.

Although C. Thorburn (captain) was playing for Scottish Districts against the All Blacks, C. Neville was sitting Exams and M. Forbes was injured, Guy's were admirably re-strengthened by J. Ross, J. Stoneham and H. Sharpe respectively.

After an inspiring pre-match talk from Rowlands (the acting captain) it was not surprising to find Guy's awarded a penalty within the first few minutes after a fine forward rush. Elliott's kick however rebounded off the post.

Guy's losing the toss were to play up-hill into the wind in the second half and it was therefore imperative that they were to score frequently in the first half. However, as the custom has been of late it was a forward who was to score for Guy's—Ross gathering the ball from a ruck bulldozed his way over for a try. Elliott safely converted.

Both packs were evenly matched for weight. Guy's rucking produced much good ball and the fast pace that dominated the game throughout brought many exciting moves from the immense repertoire that was called from the base of the scrum. It was from such a move that Rowlands dropped a fine goal from 35 yds. Just on half time The Colleges were awarded a penalty which they duly converted. This was an elementary mistake by Guy's in front of their own posts.

Despite the slope and wind Guy's continued to counter attack some very fierce Loughborough onslaughts. Guy's were again to be penalised for a scrum-mage infringement and Loughborough kicked a goal. However, it was the low standard of refereeing that had marred play for both sides that was to eventually decide the game. In the closing minutes of the game the visitors were penalised for a yet unknown reason 30 yards from in front of their posts. Loughborough confidently converted to win 9—8.

Guy's were fated, for they had controlled their opponents' moves, dominated the style of play and had held territorial advantage, and yet their threequarter-line was unable to score. But for this, the game should have been theirs.

ATHLETICS

The 15th November, heralded the University of London 13th Winter Field Events and Relays Competition for the "Tjalve" Trophy and Winter Relays Cup.

Examinations and Rugby Commitments made the raising of a team for this winter event at Motspur Park an even harder task. It was therefore a fine collective effort that enabled Guy's to tie for the "Tjalve" Trophy—especially as the field events are decided on the aggregate of two competitors from each college. Many of the Guy's team competed in more than one event.

Even greater was the achievement of the relay teams to win the Relays Cup for the first time since 1927.

Miss R. Dow, (2nd M.B. Student) solely participated in the women's events with admirable spirit.

RESULTS

4 x 110 yds. Relay.—1st, (G. Voss, J. Shutes, D. Barford, F. Nwator).

220 x 220 x 440 yds. Relay.—1st, (D. Barford, F. Nwator, T. Margan).

880 x 880 x Mile Relay.—4th, (A. Fallowfield, D. Choat, B. Smith).

Shot.—1st, A. Ross; G. Voss.
Discus.—1st, A. Ross; G. Voss.
Javelin.—2nd, B. Harley; G. Voss.
Long Jump.—2nd, B. Watson; J. shutes.
Triple Jump.—3rd, B. Watson; J. Shutes.
High Jump.—3rd, J. Shutes; B. Walsh.

Women's Events:—

100 yds.—2nd, R. Dow.
Long Jump.—1st, R. Dow.

At the Annual General Meeting of the Athletics Club the following officers were elected for 1967-68:—

Captain: J. E. Price.
Secretary: G. C. Voss
Sports Diary Secretary: M. Bates.

HOCKEY

The ladies' Hockey Club is indeed flourishing with three wins in four games. Unfortunately, the recent influx of Freshers has done little to support the side, which consists mainly of last year's players plus a few keen Freshers.

We congratulate Anna Walley on gaining a 1st XI place for the University at left-half and also Rose Thorburn, who has retained her 2nd XI University place right-back.

We also congratulate Mr. Appleby who is now regularly playing for the University of London Men's Hockey XI.

"CLIMB THE GREASED POLE"

To celebrate the opening of the new play of this name at the Mermaid Theatre, a team of six Guy's men accepted a challenge from a St. Thomas's team to "Climb the greased pole". This is a popular American sport imported from Italy and forms part of the St. Anthony's day celebrations in New York. The pole was kindly provided by the Corporation of London, erected outside the Mermaid by Turiff Construction Ltd., and freely covered with soft industrial soap by their workmen. The pole was about 35 feet high.

A good crowd of Guy's supporters arrived in time to witness the arrival on the scene of one of the famous Whitbread Drays, bringing a barrel of beer for the refreshment of the teams and spectators alike. After our non-climbing captain had graciously given a brief interview to the B.B.C., he proceeded to win the toss and sent St. Thomas's up the pole first. Our team looked very worried when they saw what little impression their opponents made on the 35 feet at their first attempt, but they climbed with great energy and skill and were well in the lead after the first round, nearly reaching the top of the impressively high pole. Two more rounds followed, and St. Thomas's gradually ate away our lead. The eventual result was a Draw, and the £50 prize, generously donated by the Mermaid Theatre, was divided equally between the two Hospitals.

P. DAVENPORT

DIARY

RUGBY
Dec. 9.—Old Cranleighians—(Thames Ditton).
,, 16.—Esher—(H.O.P.).
,, 30.—Old Merchant Taylors—(Croxley Green).

HOCKEY
Dec. 9.—Bexleyheath—H.
,, 16.—South Essex—H.

SOCCER
Dec. 6.—*Charing Cross Hospital—A.
,, 13.—*Middlesex Hospital—H.
*Denotes University Hospitals League Fixture.

HOCKEY

GUY'S v. Wimbledon 2nd XI

at Wimbledon 11th November

Result: won 1—0

This was a travesty of a game of hockey which regrettably reminded one of the much publicised football match between Celtic and Racing Club, Argentina, in that it consisted of an ever-increasing incidence of fouls— at first unintentional and later deliberate. Practically no control whatever was exercised by the umpires and the game got out of hand.

In the first half, Guy's looked the better side, and scored what proved to be the winning goal, following up well from a short corner shot.

However, tempers began to fray in the second half when first one side and then the other went unpenalised for fouling. There were some who took advantage of the situation, others who became amused or disinterested in such proceedings, and on the Guy's side only Cripps, Crafts D. and goalkeeper Clark, who saved a penalty flick, came out with flying colours for control of temperament, but still a hundred per cent effort.

Another scalp then, but a match best forgotten! We hope the Southern Counties Umpiring Association will be able to provide us with a stricter umpire and that Wimbledon will be able to find a full-time umpire and not a 5th XI player to do the job, when we meet next year.

J. K. CRAFTS

GUY'S v. GRAVESEND

18th November, 1967

Guy's, with a radically changed team (position-wise), met quite a strong Gravesend team on a perfect afternoon. Immediately after the Bully Off, and an unnoticed foul by a Guy's half-back, the ball was taken into the Gravesend circle where Dodd ran over it and Goodhart scored. There was some doubt as to whether the former player was off-side, but the goal was allowed. Time:- 15 seconds. The first half continued as a closely fought game with few chances for either side except one beautiful cross from the right wing which was completely missed by two Guy's forwards. In the second half the Guy's forwards were working well together but failed to produce another goal. Gravesend eventually scored off a deflection from a short corner making the final score a 1—1 draw. Credit must go to D. Crafts and M. Vellacott in defence and the team as a whole had probably its best game of the season. Many thanks to our distinguished supporters whose encouragement was invaluable.

Team: R. Clark; D. Crafts, M. Vellacott C. Pearson, R. Kendrick, N. Turfitt, S. Cripps, J. Crafts, N. Dodd, T. Owen, R. Goodhart.

N. DODD

GUY'S v. SURBITON II

Away November 25th, 1967

Result: lost 2—1

Guy's lost their unbeaten record to a side which was superior in all departments of the game. Playing on the fine Surbiton pitch, Guy's were just not quick enough nor accurate enough with the ball. The defence played fairly well, with Clark in goal and Pearson at centre-half outstanding. Clark at the moment must rate for the most improved player award. Generally, however, there was a lack of cohesion between the halves and forwards. A new formula must be found to obtain hard, accurate crosses from the wings, with somebody in the middle with the ability to convert the scoring chances in the goal.

From the bully-off Surbiton showed their ability with the ball, moving quickly down the wings, and soon the Guy's defence was under heavy pressure. It was not until late in the first half that they were able to score, due mainly to some good goalkeeping and also a fair share of bad luck for the Surbiton forwards. They also showed lack of a striker in the centre and thus the supply of ball from both wings was generally wasted.

In the second half the pattern was much the same but generally Guy's improved in their midfield play and some good moves were produced, and the Surbiton 'keeper was called into action on a number of occasions. Surbiton then scored again through their inside-left who hammered home a cross from the right. Soon after this Guy's scored through Goodhart, who used his speed to beat the Surbiton defence onto a through ball and beat the advancing goalkeeper with a well placed push. Thus the final score was arrived at and it was obvious that against a first class defence the Guy's forwards lack real scoring power, and it must be hoped that the answer to this problem will be found before the first round of the Cup.

Team: R. Clark, D. Crafts, M. Vellacott N. Turfitt, C. Pearson, R. Kendrick, A. Godfrey S. Cripps, N. Dodd, J. Crafts, R. Goodhart.

R. W. K.

LADIES' HOCKEY

GUY'S v. UNIVERSITY COLLEGE 1st XI

Wednesday, 18th October

Our first match was against a very strong team and we lost 6—0. The whole pattern of the Guy's game was defensive—the defence played well, especially the Goalkeeper, who had to work very hard, but the forward line was slow and muddled; consequently we never really had many opportunities to shoot.

GUY'S v. ROYAL VETERINARY COLLEGE

Wednesday, 8th November

Despite the fact that this was a rather rough game, Guy's won 4—2. Playing against a slower side than U.C. the Guy's played together better and were quicker onto the ball than their opponents.

GUY'S v. L.S.E.

Wednesday, 15th November

This was a 6-a-side match as neither side could raise a full team. It was a very energetic game and Guy's played well and deserved to win, the score being 7—3. Passing between players and stickwork have improved, and there are the makings of a really good team.

GUY'S v. BEDFORD COLLEGE 1st XI

Saturday, November 18th

1st Round K.O. University Cup. Tournament

Despite the fact that this was a cup match, Guy's was unable to field a full team, only 8 players being available.

But all played very well to beat a full Bedford XI by 2 goals to 1. The Bedford College

side were not particularly strong and rather slow and the Guy's players took full advantage, making good interceptions and being generally faster onto the ball. Our stickwork and dodges were also better, especially as shown by the L.H. A. Walley. The score at half time was 1—0 to Bedford and it was only through hard work that we managed to win. It is a long time since Guy's have won a first round match in this tournament and I do hope we are going to be successful, enthusiasm not seeming to lack at the moment !

Players: E. Clyma, R. Thorburn, D. Evans, A. Little, A. Walley, A. Collins, A. Dornhorst, K. Thorne, M. Fortnam, E. Hogwood, F. Griffith, P. Benson, C. Shrimpton, R. Dow.

Our thanks to members of the Men's Hockey Club who have umpired for us.

Forthcoming fixtures:—

Wed., Nov. 22nd: U.H.V. v. Oxford University. A.

Sat., Nov. 25th: Guy's v. Q.M.C. A.

Wed., Nov 29th: Guy's v. R.H.C. 2nd XI. A.

Wed., Nov. 29th: U.H. v. Cambridge U. A.

Sat., Dec. 2nd: Guy's v. King's College. A.

2nd Round K.O. Tournament

Wed., Dec. 6th: U.H. v. Reading U. A.

Wed., Dec. 6th: Guy's v. Goldsmith's. A.

SOCCER

GUY'S 1st XI v. KING'S COLLEGE 1st XI
U.L. Premier Division

Away 1st November, 1967

King's won the Premier Division, the University Cup and the six-a-side tournament last season, they are thus the strongest side Guy's are likely to face this season.

Once again Guy's kicked off in pouring rain. The King's team looked quite strong in defence, but despite his size the King's centre half proved slow and was easily beaten in the air. As is usual Guy's defence proved lacking and the King's attack scored two quick goals early in the match.

However, Guy's settled down and good football by Elias and McClure had the King's defence at full stretch. From outside the box McClure let fly with a terrific shot which left the King's goalkeeper standing. Guy's should have equalised through Lindridge who shot wide as the King's goalkeeper came out to narrow the angle. The Guy's forwards were moving the ball well and Jacobs was having a good game on the wing. A hard centre from Elias was headed inches over the bar. The equaliser did not come and the score at half-time was 2—1.

The second half was a repetition of the first. Lack of co-ordination in the defence and poor calling for the ball allowed the King's attack to get two more easy goals Lindridge pulled one back for Guy's, who were lacking in finishing.

King's, who were playing a 4-3-3 formation dominated the mid-field, and with the Guy's defence lying too square, found no difficulty in adding two more to their total.

McClure added another which he well deserved. Final score 6—3. Guy's showed some good football, but lacked in finishing and also in co-ordination in defence.

Team: Wood; Davey, Evans; Nash, Watt-Smith, Lovell; Jacobs, Elias, Lindridge (capt.), McClure, Harrison.

U.L. Cup, Round 1
GUY'S v. CHELSEA COLLEGE

At Home Saturday, 2nd December

Result: won 4—1

After an impressive performance at centre-forward in the second half of the previous game, Davey retained the position for the vital Cup game.

There was a typical Cup atmospher e as the game started, and the early exchanges were fast and furious. Guy's were unlucky not to take an early lead when a header from Lindridge flew past the post following an impressive build up. However the Hospital side did not have to wait long for a goal for after eight minutes Davey screwed the ball home from close range. The presence of Wood in goal, back after being injured, seemed to have a steadying effect on the no-nonsense Guy's defence. The strong Guys tackling was worrying the Chelsea side, and following an incident between Watt-Smith and the opposing centre-forward, referee Farber was struggling to retain control. However, Guys continued to play good football, and McClure went close to increasing their lead.

With the interval score at 1—0 in Guys favour, the referee called the two captains together for a "cooling-down" talk.

Guy's opened strongly in the second half, and after seven minutes increased their lead through an excellent goal by Davey. The big centre-forward, turning round, hit the ball on the volley into the far corner of the net, leaving the 'keeper no chance. Chelsea were determined to keep in the game, and although they moved sweetly up to the penalty area, the Guy's defence covered well and Wood was not troubled in goal. However, Chelsea did score from the only Guy's defensive lapse of the game. Poor covering by Watt-Smith from a corner allowed the tricky opposition number the only time of the game Guy's lost overall eight to flash a header into the Guy's net. For control, and five minutes later were rather lucky when they were awarded a penalty, unnecessarily given away by the opposition. The Chelsea protests were brushed off by the referee, and Lindridge swiftly despatched the spot kick to the net. The persistent pettiness of the College side continued, resulting in the booking of the Chelsea left-half. Just on time, Poole settled the issue, eluding the defence to slip the ball home.

This was Guy's best performance of the season, and at last, the y began to look an impressive side.

Guy's: J. Wood; S. Milnes, K. Taylor; R. Lovell, S. Watt-Smith, I. Nash; D. Jacobs, S. Poole, R. Davey, I. McClure, D. Lindridge (capt.).

R. LOVELL

GUY'S v. Q.M.C. U.L.L.

Home Wednesday, 8th November, 1967

Result: lost 7—0

With memories of their 2—0 defeat in the cup last year, Guy's hoped to have a close game with Q.M.C. These hopes were dashed, as the more efficient 4-3-3 formation of Q.M.C. found Guy's badly lacking in marking and covering. Wood, the Guy's goalkeeper, would probably have done better without the struggling Guy's defence, who more often than enough blocked his view.

It was thought that Guy's would learn by their mistakes early in the season, but it looks like a long hard lesson. Possibly, if the same team played together every Wednesday and Saturday the teamwork would improve.

The Q.M.C. game will go down as yet another defeat in the Premier division; it is hoped that the team can settle down and play as a team.

Team: Wood; Nash, Evans; Lindridge, Watt-Smith, Lovell; Jacobs, McClure, Ward, Elias, Leeburn.

D. LINDRIDGE

SOCCER

The Soccer Club would like to welcome S. Docherty who will be coaching them every Monday at William Penn School north Dulwich (6 p.m.—8 p.m.).

They also would like to thank Mr. G. Hazlett an ex-Celtic player for his help in finding a gym and a regular coach.

WATER POLO

U.L.U. KNOCKOUT

Tuesday, 28th November, 1967.

The tournament was a handicap, the teams being seeded according to which division of the U.L.U. League they were in last season.

Guy's II went out after a close game with the Royal Vet. College. The match started slowly with Guy's attacking most of the time. The opponents were given little leeway by Guy's defence in the first half. By full time the scores were level—Wright scoring Guy's goal; but in extra time the Royal Vets. scored twice to win 3—1.

Guy's I played Imperial College in the first round and made very heavy weather of it. Despite being given no end of chances, only the two goal handicap had been erased by half-time, with goals by Froom and Northcott. At the beginning of the second half the ball was passed back and back to the penalty area, where a boob occured and I.C. got a penalty from which they took the lead. From then on, Guy's had nearly all the possession and free men in front of goal on several occasions. But there must have been a short-sight epidemic considering the number of sensible passes, and to the crowd's incredibility and vociferous delight it seemed that Guy's were going to lose until Foulds scored the equaliser and then Northcott scored just before the end to win 4—3 on aggregate.

The second round was expected to be difficult, as the opponents were the strong Mary's Hospital side. Any hopes of just defending the two goal advantage ended as Mary's scored three goals in the first couple of minutes, and a fourth before half time. But Guy's were playing quite well and only allowed Mary's one goal in the second half, even though they had not noticeably eased off, to lose on aggregate by 2—5.

HOSPITAL INFORMATION

APPOINTMENTS VACANT

GUY'S-MAUDSLEY NEUROSURGICAL UNIT

Applications are invited for the resident post of **Senior House Officer** for six months commencing 1st February 1968. The Unit, which is housed in the Maudsley Hospital, serves both Guy's Hospital and the Bethlem Royal Hospital, and the Maudsley Hospital. Applications giving details of experience and the names of two referees, should be made by **22nd December 1967** to L. H. W. Paine, House Governor, Maudsley Hospital, Denmark Hill, London, S.E.5.

APPOINTMENTS

GUY'S HOSPITAL

December 1st, 1967

House Surgeons

To

Professor Sir Hedley Atkins — Mr. M. J. B. Farebrother, 3 *months*

Mr. Wass — Mr. M. J. Lockwood, 6 *months*

Mr. Blackburn — Mr. A. Kumar, 3 *months*

Mr. Lawrie — Mr. S. R. C. J. Stanley-Little, 6 *months*

Mr Glover — Mr. A. P. Freeland, 6 *months*

Mr. Brain — Mr. A. Loach, 3 *months*

Mr. Beard — Mr. R. S. Carruthers, 6 *months*

Mr. Maynard — Mr. J. H. Newman, 3 *months*

House Physicians

To

Dr. Mann, Dr. Scott and Dr. Bishop — Mr. J. G. Pickering, 3 *months*; Mr. M. G. Falcon, 6 *months*

Dr. Hardwick, Prof. Trounce and Dr. Deuchar — Mr. P. D. M. Ellis, 3 *months*; Mr. N. Irish, 6 *months*

Dr. Baker, Dr. Houston and Dr. Grimble — Mr. D. E. P. Shapland, 3 *months*; Mr. B. D. W. Harrison, 6 *months*

Dr. Kauntze and Dr. Joiner — Mr. R. C. G. Rowe, 3 *months*; Mr. J. J. Halliday, 6 *months*

Prof. Butterfield, Dr. MacLean and Dr. Lessof — Mr. R. A. C. Hughes, 3 *months*; Mr. K. G. E. Brown, 6 *months*

House Surgeon to the Surgical Unit

Mr. J. W Wright, 6 *months*

Gynaecological House Surgeon

Miss S. Haslewood, 3 *months*

Throat and Ear House Surgeons

Mr. J. L. Williams, 3 *months*

Mr. K. H. Riding, 6 *months*

Orthopaedic House Surgeons

Mr. P. J. Leopard, 3 *months*

Mr. A. G. D. Budhlall, 6 *months*

Genito-Urinary House Surgeon
Mr. J. R. Rolph
6 *months*
Children's House Phyicians
Mr. B. W. R. Moore
3 *months*
Mr. R. C. Bucknall
6 *months*
House Physician to Dr. Bishop and Radiotherapy
Mr. W. R. L. Clemmey
3 *months*
Casualty Officers
Mr. A. L. G. Peel
3 *months*
Mr. C. C. Penney
3 *months*
Mr. G. F. Rushforth
3 *months*
Mr. D. L. Ingram
6 *months*
Mr. K. Burshan
6 *months*
Mr. D. R. Vernon
6 *months*
Resident Obstetrician
Mr. C. G. Leach
3 *months*
Mr. P. J. C. Trenchard
6 *months*
Neurological House Physician
Mr. R. B. Stott
3 *months*
Dermatological House Physician
Mr. R. J. Eady
3 *months*
House Physician in Child Psychiatry
Mrs. A. M. Birch
3 *months*
House Surgeon to the Thoracic Unit
Mr. A. G. Spitzer (S.H.O.)
3 *months*
Mr. D. J. Peters
6 *months*
House Physicians in the Department of Psychological Medicine

Miss W. M. Rostron	1.10.67—31.3.68
Mr. M. O. Aveline	1.10.67—31.3.68

Resident Anaesthetists
Miss S A. Kidd
3 *months*
Mr. A. M. Morris
3 *months*
Mrs. I. M. J. Mathias
6 *months*
Mr. J. F. Searle
6 *months*
R.M.O.s in Nuffield House

Mr. D. J. Hendrick	1.7.67—31.12.67
Mr. P. R. Dorken	1.9.67—29. 2.68
Mr. J. M. I. Iveson	1.1.68—30. 6.68

Children's House Physicians at Evelina Hospital

Mr. C. L. Newman	1. 8.67—31.1.68
Mr. R. A. Y. Pietroni	1.10.67—31.3.68
Miss M. T. Cunningham	1.12.67—31.5.68
Miss D. P. L. Gorvette	1. 2.68—31.7.68

ST. OLAVE'S HOSPITAL
House Physicians to Dr. Cox and Dr. Mason:
Miss A. de C. Evans
6 *months*
Mr. J. H. Topham
3 *months*
House Surgeon:
Mrs. C. A. Topham
6 *months*
Senior House Surgeon:
Mr. J. G. Cochrane
6 *months*
Gynaecological House Surgeon:
Miss J. Tatteossain
3 *months*
Casualty Officer:

NEW CROSS HOSPITAL
House Physicians in Medicine and Geriatrics:
Mr. J. C. Robertson (S.H.O.)
3 *months*
Mr. A. P. Warin
3 *months*
Miss E. Cosgrove (S.H.O.)
6 *months*
Mr. N. C. Hamblyn
6 *months*
Orthopaedic House Surgeons:
Mr. W. P. J. Onyeama
6 *months*
Mr. M. H. Henein (S.H.O.)
3 *months*

BECKENHAM HOSPITAL
House Physician:
Miss R. A. Baker
3 *months*
House Surgeon:
Mr. R. F. J. Matthews
3 *months*

LEWISHAM HOSPITAL
House Physician to Dr. Price:
Mr. R. P. Juniper
6 *months*
House Physician to Dr. Roberts:
Mr. S. C. A. Davoodbhoy
6 *months*

KENT AND SUSSEX HOSPITAL
House Physician:
Mr. J. P. H. Jago
6 *months*

ORPINGTON HOSPITAL
House Surgeon:
Mr. M. A. Preece
3 *months*
House Surgeon with E.N.T.:
Readvertised
6 *months*
House Surgeon with orthopaedics:
Readvertised
6 *months*

PEMBURY HOSPITAL
House Surgeon to Mr. Gibson:
Mr. R. K. Jacoby
3 *months*
House Surgeon to Mr. Lavy:
Mr. P. M. Wood
6 *months*
House Physician:
Mr. S. A. L. Ceesay
6 *months*

ST. NICHOLAS HOSPITAL
House Physician to Dr. Scott:
Miss R. C. Radford
6 *months*

MILLER HOSPITAL
House Physician to Dr. Hartley and Dr. Lessof:
Mr. T. Gibson (S.H.O.)
6 *months*
Mr. A. B. Bevan-Jones
3 *months*
Mr. D. P. G. Griffiths
6 *months*
House Surgeon with Urology:
Mr. N. H. White
3 *months*

House Surgeon to Mr. O'Flynn:
Mr. K. Kermani
6 months
House Surgeon to Mr. Candy:
Mr. D. L. Beales
6 months

P. J. HELLIWELL,
Superintendent

November 7th, 1967

PASS LIST

ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF GLASGOW
Fellowship
P. J. Cook

ROYAL COLLEGE OF SURGEONS OF ENGLAND
F.F.A.
Juliet Boyd

CONJOINT BOARD
D.A.
Juliet Boyd

ROYAL COLLEGE OF PHYSICIANS OF EDINBURGH
Membership
J. D. Dow

UNIVERSITY OF LONDON
THIRD (M.B., B.S.) EXAMINATION
Pass

M. K. Anto
Rosemary A. Baker
R. J. Birts
E. J. Bowen-Jones
J. M. Brummitt
G. D. Budhlall
J. R. K. Butchey
L. D. Byer
A. K. S. Cheng
R. A. J. Eady
Ann de C. Evans
A. P. Freeland
Christine Garrett
J. R. Gibbs
A. J. Hamilton
Christine M. Holliday
N. Irish
J. P. H. Jago
R. P. Juniper
A. Kuczynski
A. Kumar
P. J. Leopard
M. J. Lockwood
Janet L. Ockleshaw
D. J. Osborne
K. H. Riding
D. S. Robins
T. Roe
R. C. G. Rowe
J. R. C. Sharp
J. D. Stephens
D. Stratton
J. H. Topham
P. J. C. Trenchard
Carol M. E. Williams
J. L. Williams
P. M. Wood
Jean M. Worms
J. W. Wright

Part I.

P. D. Ashford
J. S. Ahworth
R. Aumeerally
N. M. Bahemuka
R. I. Bailey
R. J. Baxter
R. A. Billings
W. L. Brander
M. W. M. Bridger
C. B. Brown
I. T. Campbell
P. M. J. Domaingue
E. Elias
Alex M. Falconer
Mary E. Fortnam
C. E. L. Freer
G. J. Gibson
R. H. Greenwood
T. A. Harrison
V. J. Harvey
Rowena M. F. Lawrence
A. Leyshon
C. R. McArdle
R. L. M. Newell
E. A. O. Orebiyi
J. G. Payne
W. J. Pike
G. G. Pugh
Jacqueline S. Pugh
B. J. Rowlands
D. B. Silk
M. A. Simpson
T. J. Tate
R. H. Thacker
D. T. L. Turner
P. L. D. Walde
A. K. Y. Walker
Judith M. Warin
R. J. Webb
I. K. Weir
Janet M. Higgs
Wendy J. Higlett
R. M. Ibbotson
R. N. Jones
J. G. Wheeler
W. J. Wiggins
R. A. Williams
R. H. Wiliams

Part II.

R. C. Bucknall
W. R. Dunham
J. N. MacLean
E. A. O. Orebiyi
E. N. Turfitt

Part III.

J. N Maclean
H. C. Sharp
R. H. Williams

Part IV.

J. K Bell
R. C. Bucknall
W. R. Dunham
J. N. MacLean
E. A. O. Orebiyi
E. N. Turfitt
R. H. Williams

Final State Examination in Nursing

Astley, S. E.
Blanco, A. M. M.
Davies, J. A.
Dixie, R. A.
Dodgson, L. C.
Dorrell, S. M.
Edwards, E. A.
Farmer, S. J.
Fennell, E.
Ferguson, E. A.
Finlay, J. M.
Gill, J. C.
Greenlees,
Gully, E. A.
Hatcher, C. M.
Holmes, C. E.
Horsfall, R. A.
Hunt, J. M.
Johnson, E. A.
Jones, M. B. J.
Jones, R. G.
Judd, A. C.
Kolesar, F. A.
Langley, A. M.
Leighton, M. A.
Mackay, C. J.
Maclean, S.
Mercer, C. J.
Moore, J. J.
Orme, M. M.
Pearce, E. M.
Pountney, S. L.
Ross, J. C.
Salmon, E. A.
Saunders, A. P.
Smalley, V. J.
Sowden, C.
Stanley, P. M.
Stewart, E. M.
Stillie, R. J.
Stoneham, A. R.
Tabner, J. H.
Taylor, M.
Thomas, E. E.
Trembath, A. M.
Trembath, S.
Turner, J. L.
Wandless, C. A.
Whittaker, C. S.
Winslade, I. J.
Wrigglesworth, P. S.
Wright, D. L.

Combined training with Moorfields Eye Hospital, London, E.C.1.
Adams, P. D.

THE CHARTERED SOCIETY OF PHYSIOTHERAPY

Atherton, S. W.
Bennett, S. P. M.
Davison, V. J.
Fyson, J.
Gilbertson, S. A. M.
Morpurgo, J. E.
Perfect, M.
Philp, D. W.
Stanford, J. E.

PERSONAL

EFFICIENT and conscientious young surgeon, wishing to gain experience in General Dental Practice, to manage a small, prosperous country practice for one year. Receptionist; Technician. Very modern equipment. Complete clinical freedom. Generous remuneration. Principal (Guy's) going abroad, temporarily. Box No. 1/12 Guy's Hospital Gazette.

MINI-VAN '64.—Excellent condition at 22,000 miles. With 2 new tyres and new battery, 2 rally seats with head-rests and back seat. Also seat belts carpets and heater. M.O.T. tested and taxed till May '68. What a bargain! at £225 o.n.o. Tel: HAM 9510 evenings.

CHANGES OF ADDRESS

Miss E. M. Allen, 81, Whitehall Road, Terenure, Dublin, Eire.

Mr. J. W. Baker, "Polruan", Pembroke Close, Banstead, Surrey.

Malcolm J. Burke, 33, Harbord Street, London, S.W.6.

Mrs. D. J. Davison, 5, O.M.Q., R.A.F. Hospital, Ely, Cambs.

Dr. and Mrs. Edward C. Lewis, Merlebank, Church Hill, Merstham, Redhill, Surrey. Tel: Merstham 2674.

Mr. and Mrs. L. Evans, L.D.S., R.C.S., Eng., Tavel, 36, London Road, Liphook, Hants.

Mrs. D. L. Hall, S.R.N., The Rectory, Strumpshaw, Norwich, Norfolk. Tel: NOR 772.

Professor W. E. Herbert, Newlands, 28, Worcester Road, Sutton, Surrey.

B. Highland "Greenridge", Chilworth Ring Chilworth, Southampton.

Michael Joseph, Kings Lodge, Kings Road, Richmond, Surrey.

Capt. and Mrs. N. J. Knott, 3, Butts Road, Heavitree, Exeter, Devon.

Dr. B. A. Latham, 46, Shirley Drive, Hove, Sussex, BN3 6UF. Tel: Brighton 57969 (home), 30, The Drive, Hove, Sussex, BN3 3JD, Tel: Brighton 778123 (consulting-rooms).

Dr. and Mrs. R. I. Muir, Appletrees, The Mardens, Ifield, Crawley, Sussex.

Sir Lindsay Ride, 8a, Stanley Beach Road, Stanley, Hong Kong.

Suzanne Audrey Sopwith, St. Charles' Hospital, Ladbroke Grove, London, W.10.

Miss M. I. Wilcock, 85, Kenilworth Road, Cubbington, Nr. Leamington Spa, Warwickshire.

BIRTHS

HICKSON—To Philip and Maureen, a daughter Lucy Margaret sister to David and Andrew, on 7th October, 1967.

KNOTT—On 15th September, to Rosemary (née Hepworth) and Capt. Nigel Knott, R.A.D.C., a son, Graham William, a brother for Andrew.

MUIR—To Audrey, (née Smith) and Dr. R. Innes Muir, a son, James Christopher Innes, at Crawley Hospital on 13th October, 1967, a brother for Alison.

MARRIAGE

LEMON—HALE—On saturday, 18th November, 1967, at St. Mary and All Saints, Plymstock, Miss Carolyn Hale, S.R.N., (Guy's 1963-67) to Mr. George Lemon, Royal Marines.

DEATH

SPERRYN-JONES—On 26th October, 1967 George Sperryn-Jones, L.D.S., R.C.S., Eng.

We would like to remind our readers that all copy for inclusion in the Gazette must be received eight days before publication date.

Copy may be sent to us c/o The Front Lodge, Guy's Hospital, or left in the "Gazette" pigeon-hole in the East Wing.

Personal notices and Birth, Marriage, and Change of Address notices must be pre-paid.

Personal notices one shilling per word (minimum £1. 1s. 0d.)
Birth, Marriage, Death, and Change of Address notices are without charge to subscribers.

Non-subscribers will pay £1. 1s. 0d. (pre-paid) for all notices other than Death.

GUY'S HOSPITAL GAZETTE

EDITORS C. B. BROWN and P. J. DAVENPORT
SPORTS CORRESPONDENT J. G. PAYNE
NURSING CORRESPONDENT E. A. MALPAS

FORTNIGHTLY TWO SHILLINGS VOLUME 81 NUMBER 2072

The opinions expressed in these columns are solely those of their authors and are not to be taken as the views of the Hospital as a whole.

Passim 675

Guy's Diary 676

Christmas Time Table 677

THE SENTINEL PILE

REPORTING '67

Guy's One Up On S.A. 678

Editorial: Might is Right 679

Porters' and Physios' Plot 680

Why Can't The English 681

Mass Murder 682

He Who Shouts Fire . . . 683

Your Stars 684

Recumbent Student . . . 685

On Nurses 685

At The Movies 686

A Christmas Story 687

News in Brief 689

Glossary of Invaluable Terms 690

Obituary 692

The Sportin' Life 693

Hospital Information 694

PASSIM

"The Christmas Truce has been reduced . . . to prevent the Viet-Cong taking advantage of the cessation of hostilities . . ."

If this statement was not concerned with what is probably the most senseless and certainly the most costly war since the end of World War II, it could almost be funny. Passim is, by tradition, apolitical, but it cannot be blind to this hideous cancer eating away at the very basis of our way of life.

Because it is Christmas, and because Christmas must mean more than holly, tinsel and presents if it is to have any meaning at all, we must not allow ourselves to have a truce with our conscience. To compare our celebrations at home, and those in America, with the squalor of the War, the homeless evacuees, the bombing and the killing, makes the horror of it all stand out starkly and accusingly. The gall of frustration rises in our stomachs, and catches at our throats when we stand face to face with the apparent inevitableness, the blind stumbling progress, of this juggernaut of a war.

By himself the individual can do little. But, by lending his support to the growing body of objection to this war, by campaigning for the reconvention of the signatories of the Geneva Settlement, and by calling for an end to hostilities on both sides, we may contribute towards the settlement of this stupid war.

"Stupid" because this is a war about ideas and will never be settled by military aggression.

A Cycle Ended

1967 draws to a close amidst tinsel and holly and the snow-bound piping of carol singers, who really should know better than to expose their collective larynx to the icy blast.

Regent Street parades its castles in the air, and Guy's turns its facade to the future '68 and all that. Pink-Sheet and Bed Crises, the Wage Freeze and Devaluation will become historical talking points, and survival of the technologically fittest will continue to be the maxim of our time.

Resolutions are made today and undone tomorrow, and it's no joke to be a turkey. Medics drape mistletoe 'round their stethoscopes, and a lot of money is spent sending cards to people who send cards back to you. A jovial spirit is abroad and in the glasses of those not driving.

We wish all our readers a joyous Yuletide and happiness in the coming year.

With the smell of the Christmas Pudding wafting towards our nostrils, and our salivary glands stimulated by the effect, we take leave of this year and meander into the next with thanks to Russell Cowan, Andrew Seal, Denis Cobell, Michael Simpson and Barbara Fink, whose wit (we hope) will help you over the last hurdle of '67.

CHRISTMAS GREETINGS

Rex and Jean Lawrie and their family wish their Guy's friends a very happy Christmas and a prosperous New Year.

Edward Chater regrets he is unable to send Christmas Cards, but wishes his friends a merry and prosperous Christmas and New Year.

GUY'S DIARY

We offer our congratulations to Mr. Patrick Clarkson on his recent election as President of the new Plastic Section of the Royal Society of Medicine.

We also congratulate Dr. Thomas Lehner on his appointment as Reader in Pathology in relation to Oral Diseases.

JANUARY

2nd Tu. 1.00 Clinical Lecture. Mr. READING.
"Cancer of the Lower Pharynx."

4th Th. 1.00 Clinical Lecture. Mr. MURRAY FALCONER.
"Mesial temporal sclerosis as the common cause of Epilepsy."

5th F. 1.00 Clinical Lecture. Department of Medicine.

Rose Ball

The Clubs' Union Rose Ball is to be held at the Savoy Hotel on Friday, 19th January, 1968. All undergraduates, graduates, and members of the consultant staff are invited and may obtain tickets from those persons named on the posters which are now on display throughout the hospital.

Time Table of Events at Guy's Christmas, 1967

Saturday, 23rd December

7.00 a.m.	Holy Communion: Patients, all New Guy's House Wards.

Sunday, 24th December *Christmas Eve.*

6.30 a.m.	Holy Communion: Hospital Chapel.
7.00 a.m.	Holy Communion: Patients, all Hunt's House and York Clinic.
8.50 a.m.	Holy Communion: Hospital Chapel.
10.45 a.m.	Morning Service: Hospital Chapel.
11.30 p.m.	Midnight Eucharist: Hospital Chapel.

Monday, 25th December *Christmas Day.*

7.00 a.m.	Holy Communion: Patients, Nuffield House and Nurses' Sick Bay.
6.00 a.m.—7.00 a.m.	Nurses' Carols in the Wards.
6.30 a.m.	Holy Communion: Hospital Chapel.
8.50 a.m.	Holy Communion: Hospital Chapel.
10.30 a.m.	Morning Service: Hospital Chapel.
12 mid-day	Patients' Christmas Dinner.
8.15 p.m.	Christmas Show: Physiology Theatre.

Tuesday, 26th December *Boxing Day.*

2.00 p.m.—4.00 p.m.	Visitors' Teas in the wards:
3.30 p.m.	Christmas Show: Physiology Theatre. Staff only.
8.15 p.m.	Christmas Show: Physiology Theatre. Staff only.

1968

Tuesday, 2nd January 7.00 p.m. for 7.30 p.m.	Staff Midwives' and Staff Nurses' Dinner in the Nurses' Dining Room. Party "A".
Friday, 12th January 7.00 p.m. for 7.30 p.m.	Sisters' Dinner at the Clothworkers' Hall, Mincing Lane, London, E.C.3.
Tuesday, 16th January 7.00 p.m. for 7.30 p.m.	Staff Midwives' and Staff Nurses' Dinner in the Nurses' Dining Room. Party "B".

EXTRAORDINARY EDITION

THE SENTINEL PILE

REPORTING '67

Saturday *23rd December*

GUY'S ONE UP ON S.A.

FROM OUR SPECIAL CORRESPONDENT

Theatres, December 6

Guy's Hospital lived up to its reputation yesterday of never being far from the frontier of human medical endeavour when it became the first British hospital to perform a total body transplant.

This amazing exercise in medical, surgical and psychiatric dexterity was performed on a 95 year old Great War veteran who had not worked for 50 years. He had been under treatment at the hospital for mild senility for 30 years, and when asked if he would consider the operation he tried to snatch at the opportunity.

The operation, which was performed in the Out-patients Department, required a medical team of 73 doctors and 1,200 nurses, which meant that the hospital was paralysed for two days, the duration of the operation.

The body of a 22 year old pop singer, who died from an overdose of heroin, was used for the transplant. His manager gave consent, feeling a sense of duty to the singer's paying public to try and preserve his memory, not least his spirit.

After the operation the patient's condition was described as encouraging, as manifested by his desire to pinch the posteriors of all the attending nurses, and persistent requests for louder pop music. It is interesting to note that he is not a diabetic.

The surgeon in charge of the case said he had no doubt about its success, although there is always the fear that the patient's mind might reject his body which would consequently slough off. He planned to give him some supportive treatment and has told him to contact the hospital immediately in case this should occur. He will be followed on an out-patient basis.

EDITORIAL

Might is Right?

Long Lane, November 30

There is talk of an uprising in the small island of St. Christopher's. This island is part of the Guy's Commonwealth, and although having a small population it has nevertheless played a significant role in the development of the mother country. For it is from this island that many of the more brilliant and successful students come.

For many years, life in St. Christopher's was a bowl of cherries. The standard of living was reasonably civilized and the cost was low, and the taxes were nominal—two pounds ten shillings per week. Over the years little change had taken place in the lives of the local people, although as humans there was always something to grumble about. But in all outward appearances they were a happy people—and this, in truth, was not denied by them when questioned.

The country thrived on its continuous import and export of academics and many tales have been told of their experiences there. To those who passed through its warm climes and jovial hospitality it will always be remembered with appreciation.

But troubled times have come upon this once happy land. The Imperial Government, through the Governor of St. Christopher's, has put the taxes up by fifteen shillings per week—a rise of 30 per cent. The populace were up in arms on hearing this outrageous increase. Little development had taken place on the island—the roads were bad, the sanitation poor, and the buildings old and decripit. In addition, there was no talk of improving this state of affairs. It was not even a packaged deal—it was an extortion.

The people met and sent representatives to the Governor—but he remained adamant. Someone made a wise suggest of sending the case to the Prices and Incomes Board, and another demanded it be scrutinised by the Rent Tribunal. All knew there was a Socialist Government in power and hoped that as staunch supporters of the Party a compromise might be made.

Over the past weeks, meetings have been held with a delegation from St. Christopher's at Lancaster House but no compromise has as yet been reached, and the delegation has threatened to return home.

Meanwhile, at home, there is talk of declaring U.D.I., and unless this appalling situation can be got under control the Government may find itself having to make another "kith-and-kin" decision.

Justification for this rise in taxes must be given, and the Minister responsible must answer for this undemocratic move.

PORTERS' and PHYSIOS' PLOT

"Sandwich Bar", December 1

The following report has been received from one of our correspondents, posthumously. We are trying to verify the report that, after smuggling this article out of Enemy hands, he slipped out of a window in Shepherd's House, down the rubbish shute and into a convenient Cement mixer—never to be seen again.

For some time now there has been circulating a most terrifying rumour that the Porters and Physios are plotting to take over the New Tower Block. As no denial of this story has been issued by the authorities, I descended into the heart of Enemy territory, searching for evidence. The conspiratorial H.Q. has been given an ingenious cover; they refer to it as "The Sandwich Bar". There I saw groups of Porters and Physios seated around "tables". Their calm demeanor did not deceive me as I struggled to overhear snatches of their conversation. It soon became apparent that their password was "pass the sugar", and that these innocent-looking groups were, in fact, working parties. The only one that I could positively identify was a large group, a member of which was heard to describe the sandwich in his hand as being "fit to use as bricks"—obviously the Building Committee!

At that moment I saw that all my worst fears were realised; there in the corner stood the brazen symbol of their hopes and ambitions—a model of the new Tower Block as these conspirators planned to build it. The Tower, a monument of light and cheerfulness, and the rest of the Hospital shrouded in a ghastly battleship grey, even the windows (cunning fiends) had been painted over. This morale-shattering move is the cruellest part of the entire plan, save only the removal of Thomas Guy from the Front Quadrangle!

I tried to find out exactly how the floors would be distributed in this Workers' paradise, but the danger of giving myself away made this a hazardous business. I did, however, discover that the very top floor was to become the Porters' Nerve Centre, the view over the whole Hospital enabling them to spot any attempt to move traffic in the Hospital and to halt it quickly. I did not discover the details of their emergency plans, but I gather that any road in the Hospital can be completely sealed off by Laundry Wagons and Rubbish Trucks in two minutes flat. The reserves of food trolleys stand by in case of the escape of an errant Rolls. By stopping the movement of traffic, they hope to avoid the accumulation of rubbish and the necessity of collecting laundry, they will then have the whole day in which to queue up to clock off.

The floors immediately below will become Porters' recreation rooms, restaurants, and a cinema.

The Physios have been assigned ten floors, subject to their co-operation in the revolt, which will be split into two groups—five remedial floors, and five punishment floors for those foolish enough to try to cross the Porters in their new way of life. A list of punishments has, I am told, already been drawn up. It is so forbidding that it would make even a Doctor of Physical Medicine blanch (if he were not already on their side).

The remaining floors will be used as residences for the Porters and the Physios. Each flat will be completely self-contained, and it is rumoured that a medical student will be chained to each flat for his five years here, acting as House Boy for the new Master races.

This, then, is all that I have been able to find out in my brief exploration. I fear that I may have been discovered, so I shall send this back to the world outside in a cheese and tomato sandwich. If any doubt what I write here, let him descend to the "Sandwich Bar" and view the grey, windowless, Thomas Guy-less model, listen to the furtive groups "passing the sugar"; and then let him say that my fears are groundless.

WHY CAN'T THE ENGLISH

FROM OUR . . .

Hunts' House Spire, December 12

The unpredictability of the British weather (the only predictable thing about it) often throws the entire country into complete confusion. If this unpreparedness was to become infectious, one could forsee the following (unlikely) happenings.

Because they had not heard that the walk had been cancelled, Preston Park is now littered with full Guinness bottles, still waiting for the walkers.

Because Matron thought that the Christmas Show was not going to be BLUE, she allowed it to be put on.

Because they thought that the College was indestructible, no provision was made to replace it.

Because the College **IS** indestructible, we have seen **three** demolition firms trying to knock it down.

Because no one expected the Residents to drink at their dinner no breathalysers were provided.

Because no one expects any trouble at the next Hospitals' Cup Final—the Police will still be there (how did that one slip in?)

Because we shall all be travelling by monorail in two years' time (or so they must hope) all car parking space round Guy's will be closed until the Tower Block is finished.

Because no one expected L**d B**** to arrive, the temperature in Theatre 1 was allowed to rise three degrees.

Despite St. Christopher's being redecorated, the occupants were surprised by the 30 per cent rise in rent.

Despite married quarters being provided for married House Officers, there has been no increase in the number of nurses wearing eye-shadow.

Because couples have been prevented from conoodling in the Park (no couples allowed through the Collonade after 11 p.m.) we now have couples conoodling in the Front Quadrangle.

Because the beer in the Students' bar is cheaper than elsewhere, it gets overcrowded and overheated (the beer and the bar).

MASS MURDER

FROM OUR CRIME CORRESPONDENT

Bermondsey, December 10

Not since the psychopathic murders committed by Bonny and Clyde during the thirties has the horror of mass killings been recorded. Yesterday, in the cold of a white-tiled room in the basement of an old four-storeyed building in Southwark, ten bodies were found. According to the home pathologist, a man of eminent position, who, for advertisement reasons has to remain unknown, the killings were the work of a madman or madmen. Whether it was a single nut working alone or in unison with another cracker is still to be revealed.

The bodies were all adults, four men and six women. Five of them had been neatly wrapped in burial shrouds and placed in coffins as if for burial, but apparently the murderers must have been disturbed, as the other five were left on the cold slabs.

There is little doubt that the whole horrific business was premeditated, down to the last brass nail. Detective Inspector Grimes of Old Irish Yard (not to be confused with the Old Irish Yard known to so many students and registrars for its patent bitter) said, "Never in all my born days have I been called upon to crack such a hard nut as this, and I've been an armchair cracker of nuts for well on thirty years."

None of the bodies have yet been identified, although the way in which each was killed was typed up on a prepared sheet and pinned up on one of the notice boards at a nearby teaching hospital (the name of which must be omitted for the same reasons as mentioned above). A student at this hospital said that he had seen this notice posted some two days previous by a rather portly man with a cap bearing the inscription GH. Further enquiry has not helped in solving this obviously crucially important piece of evidence.

A national alert has been sent to all border posts and airports for two unknown characters with spilt blood on their heads, and a price on their coats.

All persons in and around the High Street on or about the 4th, or over and above either, please contact Old Irish Yard at HELP O.

FROM OUR ARCHAEOLOGICAL CORRESPONDENT

An unusually large number of bones have been unearthed in Guy's Hospital. These are unusual in that they are marked faintly with the letters spelling BEANEY, and are said to be typical of the Brontosaurus Dynasty and all show characteristics of the "Simpson" syndrome.

The Guy's archaeological Society are organising a search for further interesting fossils under the site of the old College. Applications to join this dig should be lodged with the Superintendent not later than January, 1972, when the site should be vacant.

He who Shouts Fire should not drink Water

(or People in Glass Houses should have Curtains)

The College, December 5

At last the College nears the end of its long drawn-out tortuous demise. With agonising groans the crumbling mortar and worm-bedevilled-wood of that ancient monument slowly revealed its innermost to its past inhabitants, but obtained little sympathy.

But a most peculiar incident took place only last week. With little but the external wall left, the innards having been totally demolished, a good deal of the woodwork was left heaped up. At regular intervals this was ignited so that the workers around could be kept alive at a reasonable temperature compatible with life. This manoeuvre, however, nearly cost a workman his life when he attempted to rapidly reheat his well-nigh extinguished self by throwing himself into the conflagration from a nearby still-erect wall. Fortunately, it suddenly began to snow quite heavily, which very quickly brought the flames to heel and the man to his senses.

But now to that peculiar incident I mentioned before. One of these fires was spotted by a sickly patient in Esther, who, being denied the pleasure of going home for Christmas, decided to put a stop to the pleasure of keeping alive from the workmen below. This infected gentleman hurried down the corridor unbeknown to Sister and called up the fire brigade. Within ten minutes the fire fighting force of Southwark, Lambeth, the City and Bermondsey was blasting the already bludgeoned College with water. Cries of "the College is on fire" hearkening back to those memorable days during the War, were heard about the Hospital. Well trained nurses, begowned and beguiled, carried out their ingrained routine of evacuating the patients. Lord Robens was called and asked whether it was his coals that had been added to the fire, an Dr. Baker was permitted to say a prayer for the sick and needy, a sudden desire which came upon him while seeing before him his former home in flames.

The following day the foreman on the site was charged with high arson, and allowed one thousand devalued pounds bail. For, the Clubs Union thought it a brilliant idea to sue the demolishers for arson and use the money to build a students' hostel.

What the Stars Foretell

by

CRYSTAL BALL

Capricorn (December 21—January 19)
Do not ride a bicycle between 3 and 4 on a Saturday morning behind a man with a squint in a Mini.

Aquarius (January 20—February 18)
Beware of water-farcy or any other sort of low comedy.

Picsces (February 19—March 20)
A man will approach you to your disadvantage in W.C.1.

Aries (March 21—April 20)
If your are a medical student try again. If not, don't.

Taurus (April 21—May 20)
Be on the alert for unexpected opportunities which might or might not possibly be envisaged as opportunities to be on the alert for.

Gemini (May 21—June 20)
If you see a road, cross it.

Cancer (June 21—July 21)
A bad temper might be to your advantage. On the other hand it might not.

Leo (July 22—August 21)
Only if you're British.

Virgo (August 22—September 21)
Avoid wearing white.

Libra (September 22—October 22)
Plant your feet firmly on the ground and water frequently.

Scorpio (October 23—November 21)
A short posterior rectangular flap enters your life.

Sagitarrius (November 22—December 20)
You'll have an arrow escape.

Sister Ada Advises

Dear Sister Ada,
If Bach composed Air on a G string for the Clavicle how many harps in a terpsichore ?
Answer: *Depends whether you are a major or a minor.*

Dear Sister Ada,
My cousin has Knock-Knees and my brother-in-law has athletes foot. How can I bring them together ?
Answer: *Funny you should have this problem.*

Dear Sister Ada,
Should nurses ?
Answer: *Only in the mating season.*

MIDDLE ARTICLE

RECUMBENT STUDENT BODY ....

The attitude of the student body to the recent introduction of white aprons seems to be singularly recumbent.

Following the absolute rejection of white coats to be worn on the wards, the authorities are insisting on the use of white aprons instead. These aprons are to be starched and changed daily, and while they must be worn at all times in the hospital, they need not be worn to H.O.P. or in the Borough High Street.

The inert attitude of the student body is indeed surprising. According to our "man in a spot" it can be explained mainly by the inherent lack of muscle fibre of this body, although cynics are suggesting the desire among students to associate themselves more closely with the nursing body.

Whatever the reason, the outcome will prove interesting, with the very likely possibility of students performing even more time-consuming, menial tasks on the wards and the adoption of a shift system by the medical school.

When asked to comment on this new regulation, Matron said, effervescently: "It will be such a joy to see so many young men and women bound so closely by one common factor. One might almost say that they will be tied to each other's apron strings . . . "

The Medical School refused to make any further comment, but it is believed in reliable circles that this is just one step towards the introduction of kilts to be worn by all students in the hospital.

We are informed by the manufacturers that the aprons are available with perspex insets on the bibs so that college ties can still be seen, in short lengths for the young at heart and with turn-ups for the conservative.

NURSES CAN'T GET ON

Today saw the closure of Caleb and Diplock (or Hairlip and Cyclops??) wards to patients for an indefinite period. This inevitable move occurred because nurses complained they could not get on with their jobs when the children made too much noise.

When it is remembered that over the last week three nurses working on these wards have developed enuresis and a fourth a primary gait, the action taken seems understandable.

Preliminary measures have been made to accommodate the homeless patients in the Will's Library, where excessive noise is no problem. Because of this the journals in the library have been replaced by children's magazines with the exception of the B.M.J. and Lancet from which, it is felt, the children will get a great deal of pleasure.

It is hoped to reopen the wards in the new year, when the nursing staff have recovered, at first to visitors only and eventually to children who promise to keep quiet.

It is for similar reasons that the labour ward is in danger of closure. The nursing staff have become increasingly irritated by the noise emitting from labouring mothers. In future all reciting of prayers, chanting of psalms, and spirituals will be treated with immediate evacuation.

AT THE MOVIES

FROM OUR ART CORRESPONDENT

Odeon, December 12

"What we've got here is a failure to communicate."

—Underground advert for this new film.

Cool Hand Luke, now showing in S.E.1, is altogether a cinematic occasion. It's entirely a matter of the performer—the singer not the song—the film is, as it were, moulded around a slightly rubric presence created by films in the first instance. Obviously I have not been alone in detecting something charming and withheld (maybe charming because withheld) in Paul Newman's movie appearances to date: that slow-curdling smile, that hazy and edgy amiability best supplied heretofore in such sterile, though centrally dramatic, movies as **The Hustler,** or **Hud,** a film for the bloodthirsty.

The directors have tried to cash in artistically on his Giocondan quality, and it must have been his besetting sin of commission that won him this Oscar. The result is a weird manner of hymn to Newman's central story.

He gets two years in a chain gang after drunkenly bashing the tops off rows of junkie syringes. Down here, in the dreadful South, he runs into a fist-fight with the gang's leader, but keeps standing up. He twice escapes, and is twice recaptured and brutalised.

It has been comprehensively noted that his white VW shines towards other cinematic saints. But he keeps cool, remembered well by fellow campers, whom he nevertheless despises; he fills the wide screen in a succession of grinning snaps at the close. Abetted by the cameraman, this perverse tribute to the enigma of Newman includes a special guest appearance by our No. 3, Suzie, with her oldie, which knocks the Scafford over-weight-for-it "I'll tell you what I'm ringing about".

Cool Hand Luke is a film for those who do not bleach easily, and refuse to look into Bertrand Russell's scrupulously ordered clean linen!

WEATHER REPORT

An accumulation of air and fluid is reported in the paricardial sac.

A CHRISTMAS STORY:

FROM OUR KIDDIES' CORRESPONDENT

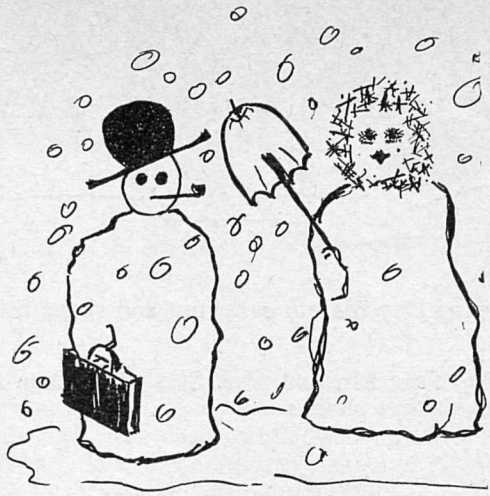
Nipnock Ward, December 2

One Christmas long ago in a blizzard as thick as the icing on a Christmas cake, if not thicker, there appeared a snowman with charcoal eyes as black of the raisins in a Christmas pudding, if not blacker. He just appeared out of the night, wearing a bowler hat, smoking a pipe, and carrying a brief case; but as is the wont of snowmen who appear in the middle of blizzards, no move did he make.

The world moved about him, and he just stood quite still and watched.

For three whole nights it snowed and snowed until it was hard to believe that there was any more snow in the sky, which there was, for however hard it was to believe that there was any more snow in the sky, it still went on snowing for the sky was full of snow, however hard it was to believe.

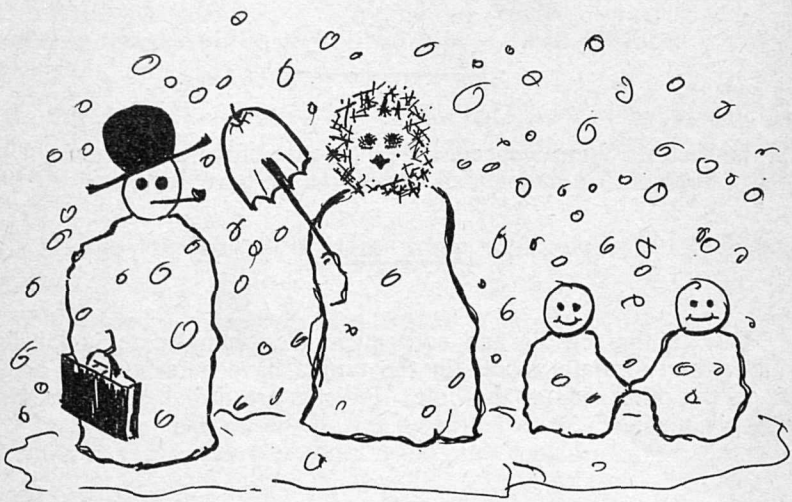
And on the fourth day a snowlady appeared in a pretty bonnet of crystals, and joined the snowman who had appeared in the middle of the blizzard.



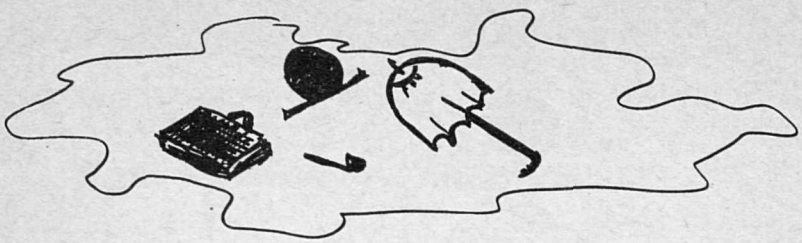
There they stood together, watching the world whitening about them.

And so, the snow fell.
The robin's breast changed colour;
The trees sprouted white leaves;
And the land was covered with a magic carpet of whiteness.
There was no wind to whistle through the trees.
Only the silent noise of falling snow.

Then the twins appeared. Twin snowchildren beside their snow mummy and daddy.



And so Mister and Mrs. Snowman and their twin children, Olga and Bertram, spent their first white Christmas together: sadly it was to be their last.



For on Boxing Day the sun came out and shone brightly from a cloudless sky.

By the New Year Mr. and Mrs. Snowman, Olga and Bertram had became one big wet puddle.

NEWS IN BRIEF:

It is rumoured that due to the highly toxic nature of the weekly "Inflams", the owner of the house at the end, opposite, has had to buy one large bull dog bitch.

In Victoria Ward a sheepish woman gave birth to twin goats. "I hope one's a nanny", she is reported to have said.

Due to the big dig and consequent workman freeze, the beds which were normally stored in the tunnel have unfortunately been left on the other side of the hole. Patients are now being offered a bath per night.

GLOSSARY OF INVALUABLE TERMS

FROM OUR MEDICAL CORRESPONDENT

A dialect or patois has arisen, used mainly by students and housemen writing up case-histories. The original meanings of the terms have mutated, until each seemingly simple word or phrase can convey a host of hidden meanings and nuances. This small selection may be of use to those who have but recently arrived on the wards, and may help them to appreciate something of what's going on around them.

n.a.d.—literally: no abnormality detected. The precise meaning of this golden and immortal phrase varies slightly according to the circumstances. It usually means that, while fully realizing that you can **always** detect **some** abnormality in everyone if you really want to, nonetheless you neither expected nor found any really gross abnormality in the area under examination. It may mean that nothing was detected because you forgot to look, or didn't dare to look—she was sitting on it, or by the time you'd got your stethoscope out, you found that the patient had slipped off to the toilet.

Patient unco-operative—he discovered you were a student, and the Casualty Officer, Houseman, Junior Registrar, Senior Registrar and Consultant had examined him before you got there.

Family History—nil relevant—forgot to ask about family history.

Prawdwicz-Neminski's sign absent—this sort of thing is usually put in to worry the Junior Registrar.

scattered fine rales—he was admitted with congestive cardiac failure, so there must have been some rales somewhere.

H.S. normal—no murmers noted—That, I suppose, was the first sound; and that was either a diastolic murmer or the tubes of the stethoscope rubbing together.

Not palpable—this doesn't of course mean it's not there, but you can probably argue your way out of it. Besides, it gives you something to say about lymph nodes and spleens, etc., which you've never been convinced you felt since you first met them in the Preclinical Class.

L.O.A.—in the Ante-Natal Clinic. You really had no idea what the presentation was, but statistics allow you to say with some confidence that it is L.O.A.

Pleasant—the patient liked you.

Nervous and irritable—the patient didn't like you.

On Examination: n.a.d.—Healthy young man admitted for minor dental operation.

On Examination: followed by two pages of negative findings—Healthy young woman admitted for minor dental operation.

Obese—bearing more adipose tissue than the examiner.

Testicles—normal size—this, too, is usually more informative of the examiner than of the patient.

S.O.B.—this may be used to indicate Shortness of Breath. Don't use it, though, if the patient is looking over your shoulder.

Absent breath sounds—Bell-diaphragm stethoscope: the lever is turned to the diaphragm, and you are listening with the bell.

Usual childhood diseases—this often means that the patient can't remember anything before the age of 27.

Grade 2 murmer—a murmer I can only just hear, if I concentrate profoundly.

Grade 1 murmer—a murmer I can hear clearly—once the Consultant has said it's there.

OBITUARY

Samuel Spit, founder of a well-known S.E. London food emporium, died yesterday at the age of 96. The tragedy occured when he looked up a lift shaft to see if it was coming. It was. His death was a crushing blow to all, and he will often be brought up over meals. He leaves a widow and a lot of indigestion.

THE WORD GAME

GEMR SQLOZTJ BUNPKCOWFADVIX H.

Answer on page 693.

From our Nature Correspondent

How to tend the domestic grape vine.

1. Feed it liberally with interesting innuendos.
2. Should be watered at least weekly with a whispering can.
3. Rub much rumour around its roots for general comfort.
4. Polish the leaves with licentious libellous lies—bought in packets of 100 from any good communications office.
5. Stir the sap monthly to encourage it to rise.
6. Inflame the flowers with tincture of bella matrona.

LOST

THE POLICE . . .

The police are wishing to interview the *irresponsible person who removed the road sign* —Great Maze Pond.

ONE PAIR . . .

One pair of night sister's bloomers marked with the initial Q and in good second hand condition. Any offers please telephone 366 after 11 p.m.

ONE LARGE DAIMLER . . .

One large Daimler vintage unknown in startling coal black colour. Numerous previous owners. Registration No. NCB 1. Please ring the Coal Board after 6 p.m. any evening except Sunday.

PERSONAL

THE GUY'S HOSPITAL SELF-SERVICE SPEEDY LAUNDRY . . .

The Guy's Hospital Self Service Speedy Laundry will wash and limply starch your white coat for the small fee of 10/6d. Swift fortnightly service every Tuesday!

A SEANCE . . .

A seance will be held in Bearer Hall every Sunday at 6 p.m. See all the Spirits under the Chapel.

JOIN . . .

*Join the Hippy Happy Gang in Guy's dis*pensary. Free shots when requested.

TO THE OWNER . . .

To the owner of Afgan Hound Sherry "Come back all is forgiven."

THE SPORTIN' LIFE

Os' AND Xs'

The finals of the noughts and crosses championships will be held on the Pavement next Thursday a.m. Spectators are requested to bring sandwiches.

ESCALATION

Owing to indisposition, the Rat Race will not take place as previously scheduled.

LE PETOMANE (with contemporary photographs)

This French book, that is now available in English, has recently been reviewed by Peter Lennon. It describes with emotional authenticity the life and career of Joseph Pujol, Prince of Petomane.

But few are able to recall the unique talent with which his name is associated, for "to perpetuate his name it is necessary to describe what he did. Not to beat about the bush, Pujol's talent was that he could *pass flatus* like nobody else in the world, before, then or since."

Believing this gift to be an immortal quality, he meant to profit, and indeed he did; being requested by the aristocracy (under the pretext of exhibiting an oddity) he performed with handsome rewards.

For 20 years he travelled Europe cultivating his métier to perfection. With the rare genius of the Karma Sutra, he daringly became an exponent of a vast repertoire of positioned f—s. With each performance, subtly modified for the occasion, he was rarely found to be in bad taste.

But, alas, he has passed, and we are left with a memory. So rarely does nature endow such greatness. But who knows which way the wind may blow next.

COCK FIGHTING

This ancient sport, believed by many to have been eradicated by the forefathers of the R.S.P.C.A. (or was it R.S.P.C.C.?), has again found popularity within these precincts.

Behind the drawn curtains the small band of enthusiasts (unfortunately at times only two have been recorded in attendance), coax and encourage their cocks before they are eagerly thrown into the ring to conquer or submit.

Previously restless and agitated by the suspended race meetings, the ardent followers welcomely divert their gambling vocation for a foot-and-mouth substitute that out-manoeuvres the computer.

The cocks are reared by meticulous personal diligence to an ecstatic biological frenzy that establishes a climax in the heart of the arena.

Viciously these birds peck their opponent until blood is drawn and the contest won.

And so this Xmas Festival Guy's will celebrate the Adoration of the Cock.

DIARY

Boxing Day. Staff v. Students. Rugger match. H.O.P

ANSWER TO "THE WORD GAME": ALPHABET

accurate metered dose of 5 mg.

contains 1700 spray doses

rapid onset

free from alcohol

with anti-bacterial action

XYLOTOX SPRAY
TOPICAL ANAESTHETIC WITH ANTIBACTERIAL ACTION
AVOID SPRAYING INTO THE EYES
PHARMACEUTICAL MANUFACTURING CO. EPSOM SURREY
STORE IN A COOL PLACE
DO NOT ATTEMPT TO BURN OR BREAK CONTAINER

XYLOTOX SPRAY

FOR PRECISE TOPICAL ANAESTHESIA

A division of

PHARMACEUTICAL MANUFACTURING COMPANY
The Local Anaesthetic Specialists
EPSOM · SURREY

WILLOWS FRANCIS LIMITED · EPSOM AND LONDON
Pharmaceutical Manufacturers since 1753

HOSPITAL INFORMATION

PERSONAL

FARNHAM, SURREY—Associate Dental Surgeon required to start in 1968, newly qualified welcome Tel: Farnham 6466 or Box No. 3/12

CHANGES OF ADDRESS

Miss G. S. Collins 265, Coxford Road, Shirley, Southampton, Hants.

S. A. R. Cooke, F.R.C.S. 14, Trinity Church Square, London, S.E.1. Tel: HOP. 5854

Dr. D. K. C. Cooper, 37 Chester Court, Albany Street, N.W.1., and National Heart Hospital, Westmoreland Street, London W.1.

Dr. T. C. Outred, Dr. Warren House, 66, Norah Lane, Hipham, Near Rochester, Kent.

Miss Jennifer M. Reckitt, "Blindwells", Strete, Near Dartmouth, South Devon.

BIRTH

FORBATH—To Drs. Nicholas and Anne (née Kenshole) Forbath, on December 6th, in Toronto, a son, Christopher Joseph Harvey. A brother for Elizabeth.

MACRAE-GIBSON—On 13th December, at home to Mary (née Monck-Mason) Dr. Neil Macrae-Gibson a daughter, Rowena Kirsty, sister for Gavin Catriona and Jonquil.

MORRIS—To Barbara, wife of Dr. George Morris, of 169 Cranley Gardens N.10., on 14th. November 1967, a son, Jeremy, a brother for Jane.

SHANNON—On 29th November, at Sandling House, Hollesley, Suffolk, to Patricia (née Goldsworthy) S.R.N., and Colin Shannon, M.B., B.S., a daughter, Alexandra Jane, a sister to Samual, George and Clare.

MARRIAGES

NEALE—JONES—On 16th December, 1967, at Chester, Miss Ann Pritchard Jones S.R.N. (March 1964—November 1967), to Lt. Michael A. Neale R.E.

PASS LISTS

THE CHARTERED SOCIETY OF PHYSIOTHERAPY

Intermediate

Beard, R. F.	Goodman, A.
Bishop, F. A	Hill, J. R.
Braybrooke, J.	Hinds-Howell, M.
Cohen, S.	Marshall, W. J.
Cran, S. J.	Stephenson, M. I.

Preliminary

McGarry, F. M.	Bowskill, J. R.
Parker, L. M. G.	Bradford, S. J.
Templeman, A. L.	Champion, W. A.
Baston, M. V.	Cliff, S. E., (Credit)
Danischewsky, N. C.	Greener, J. M.
Simmonds, S.	Harvey, J. L.
	Holburn, L. M.

We would like to remind our readers that all copy for inclusion in the Gazette must be received eight days before publication date.

Copy may be sent to us c/o The Front Lodge, Guy's Hospital, or left in the "Gazette" pigeon-hole in the East Wing.

Personal notices and Birth, Marriage, and Change of Address notices must be pre-paid.

Personal notices one shilling per word (minimum £1. 1s. 0d.)
Birth, Marriage, Death, and Change of Address notices are without charge to subscribers.

Non-subscribers will pay £1. 1s. 0d. (pre-paid) for all notices other than Death.